TABLE OF CONTENTS FOR SECTION 4 - CHILDREN IN CARE

TABLE OF CONTENTS FOR SECTION 4 - CHILDREN IN CARE

TABLE OF CONTENTS FOR SECTION 4 - CHILDREN IN CARE

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401 Scope and Purpose

The primary child welfare goal of the Division of Family and Children is to help children attain permanency. This is accomplished by focusing on the safety and best interests of the child. Any decision regarding the child is to be consistent with this goal.

If the safety and best interests of the child are best served by removing the child from the home, then out-of-home care is to be considered. Out-of-home care may be provided through kinship care in the home of a relative or through foster care in a foster family home, or a group-care setting, depending upon the individual needs of the child. The family case manager (FCM) is responsible for working with all persons involved in the child's care. Our interests always must focus on the child. The FCM's goal is to develop a permanency plan for the child, utilizing input from the child's legal parent(s), appropriate relatives, and foster parent(s); and to implement that plan as efficiently as possible consistent with the child's well-being and within the parameters of state and federal statute, rules and regulations.

402 Legal Base

Federal Law: 42 USC 620-628(b); 42 USC 629-629(e); 42 USC 670-679(b);42 USC 671; 42 USC 675 and 42 USC 677.
Indiana Juvenile Code: IC 31-9; IC 31-10-2; IC 31-16-10; IC 31-34; IC 31-38; IC-40; IC 12-17-9, IC 12-17-10, and IC 12-17-11.

403 The Placement Process

It is in a child's best interests to have as few changes in placement as possible. Any movement of the child from one placement to another is to be kept to a minimum. Therefore, any out of home placement, including what is thought to be a short-term initial placement, is to be made with as much consideration as time allows to matching the needs of the child with the strengths of the out-of-home care resource. Each move the child makes is to be made as though it were the last move.

There are many placement options available when out-of-home care is required for a child. A thorough assessment of the child's needs provides the foundation for determining what type of placement will be in the child's best interests. The following information delineates the placement process.

403.1 Selection of the Placement

42 USC 675, enacted June 17, 1980, requires that each child's case plan be "designed to achieve placement in the least restrictive (most family-like) setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child."

403.11 Types of Placements

The following presents the types of placement resources available for children needing out-of-home care:

403.111 Relative Homes (Kinship Care)

IC 31-34-6-2, as amended by PL 142-1993, requires a court to consider placing a child alleged to be a child in need of services (CHINS) with an appropriate family member before considering any other placement. Kinship care often offers the child a family-like living experience that most closely resembles the child's own home. Therefore, the county office of family and children (COFC) is to attempt to locate relatives as placement resources first. A relative placement may be considered appropriate when the minimum sufficient level of care for the child is met and the relative can demonstrate that the best interest of the child is the primary focus.

Any child in substitute care is entitled to equal protection. Therefore, the approach to obtain licensure for a relative home placement is to be the same as that for licensure of a foster home placement. That is, the basic procedures regarding evaluation, case documentation, training offered and required, supervision, and opportunities for receiving financial assistance are to be the same. Licensure is to be obtained in a timely manner. See section 6 regarding licensure of a relative home. See Section 9, subsection 903.22 and 903.23 regarding the IVE-FC eligible child in relative placement.

403.112 Foster Family Homes

A foster family home provides a family-like living experience for a child who is suited for family relationships. A foster family home must be licensed by the Central Office of the Division of Family and Children (DFC) upon the recommendation of the COFC or a licensed child placing agency. Refer to IC 12-17.4-4 concerning foster family home regulation and Section 6 of this manual regarding licensing of foster family homes.

403.1121 Special Needs Foster Family Homes

The category of "special needs foster family home" is established in PL 211-1999. It is defined, for purposes of regulatory statute (IC 12-17.4), as a foster family home that:

(1) provides care for a child who has a mental, physical, or emotional disability; and who will require additional supervision or assistance in behavioral management, activities of daily living, or management of medical problems; and

(2) meets additional requirements specified in IC 12-17.4-4-1.7 as outlined below.

Training requirements for a special needs foster family home include:

(1) participating in the 20 hours of pre-service training required to be licensed as a foster family home; and,

(2) within one (1) year of licensure as a foster family home and annually thereafter, participating in 20 hours of in-service training - 10 hours as required to maintain a foster family home license and an additional 10 hours

that includes specialized training to meet the child specific needs.

A special needs foster family home may not provide supervision and care to more than eight (8) individuals each of whom is less than 18 years of age or is at least 18 and is receiving care and supervision under an order of a juvenile court. No more than four (4) individuals may be under the age of six (6) years. These totals include the children for whom the provider is a parent, stepparent, guardian, custodian, or other relative. The Division of Family and Children (DFC) may grant an exception to this limitation if it is determined that placement of siblings in the same special needs foster family home is beneficial. The DFC is to consider the unique needs of each special needs foster child in determining the appropriate number of children to be placed in the home. The DFC may require a special needs foster family home to provide supervision and care to less than the maximum number allowable based on that criteria.

403.1122 Therapeutic Foster Family Homes

The category of "therapeutic foster home" is established by PL 211-1999. It is defined, for purposes of regulatory statute (IC 12-17.4), as a foster family home that:

(1) provides care to a seriously emotionally disturbed or developmentally disabled child,

(2) provides the setting in which the child receives treatment via an integrated array of services supervised and supported by qualified program staff from Family and Social Services Administration, a managed

care provider contracted by the Division of Mental Health, or a licensed chlld placing agency; and

(3) meets additional requirements under IC 12-17.4-4-1.5 as outlined below.

Training requirements for a therapeutic foster family home include:

(1) participating in 30 hours of pre-service training that includes 20 hours of pre-service training for licensure as a foster family home and an additional 10 hours of pre-service training in therapeutic foster care; and,

(2) within one (1) year of licensure as a therapeutic foster family home, and annually thereafter, participating in 20 hours of training that includes 10 hours of training required to maintain a license as a foster family home and an additional 10 hours of training required to maintain a license as a therapeutic foster family home.

A therapeutic foster family home may not provide supervision and care to more than two (2) foster children at the same time, excluding the children for whom the applicant or operator is a parent, stepparent, guardian, custodian, or other relative. The Division of Family and Children may grant an exception to this limitation if the placement of siblings in the same therapeutic foster family home is beneficial or in the best interests of the foster children residing in that home.

403.113 Group Care Facilities

The following types of group care facilities are licensed by the Central Office of the Division of Family and Children:

(1) Group Home

The capacity of a group home is limited to 10 or fewer children, six (6) years of age or older who are apart from their parents or guardian on a 24 hour a day basis and who have demonstrated the ability to follow direction and take appropriate action for self preservation. (470 IAC (Indiana Administrative Code) 3-14-13) Group homes may be considered for children who can live safely in the community and do not pose a public safety threat but who require a more structured experience than a foster family home. Also, group homes may be used to provide a

transition for children leaving institutional care and returning to community and family living.

(2) Child Caring Institution

The child caring institution has a capacity of more than 10 children six (6) years of age or older (470 IAC 3-11) and may be used for children who cannot adapt to the living experiences in a foster home or group home. For appropriate children, an institution can provide specialized services and a group living program in accordance with an individual treatment plan for each child.

(3) Shelter Care Facility

A shelter care facility may be licensed as either a group home or an institution (470 IAC 3-15; 470 IAC 3-12). These facilities usually accept children for a defined temporary period of time (usually less than 30 days) while more permanent plans are being developed, and thus are designed for emergency, short-term placement as opposed to more extended placement periods.

403.114 State Institutions/Hospitals

Several Indiana state agencies operate residential facilities that serve children. The Department of Health, the Department of Correction and Family and Social Services Administration's Division of Mental Health each operate facilities for the care and treatment of children who present severe physical, mental, and emotional problems. These facilities are described in the following subsections:

(1) State Department of Health Institutions for Children

The Indiana State Department of Health (ISDH) operates several specialized state schools for children with various qualifications and needs.

(a) The Indiana Soldiers' and Sailors' Children's Home: A residential institution for children in need of services. While the home is open to all Indiana children, preference is given first to those who are the children of current and former armed forces personnel and second to specified relatives of such military personnel. There is no residency requirement other than the child being in Indiana immediately prior to application for admission. Application is made directly to the home. IC 16-33-4-11 requires that a review committee, of which a designee of the Secretary of FSSA (DFC) is to be a

member, is to determine the appropriateness of placement at the facility. If a placement is considered to be appropriate by the committee, the superintendent is to receive the child into the home, if the child meets the criteria for placement. The home will not accept a child who requires residential placement in a detention center or a secured facility. The social work staff provides casework to individual children and has responsibility for liaison work in the child's home community. (IC 16-33-4)

(b) The Indiana School for the Blind: An educational institution for children who are educable but who cannot make satisfactory progress in regular public schools because of a serious visual deficiency. The institution offers education, care, and special disability-based training for children three (3) years old through high school age. Admission is by direct application to the school. (IC 16-33-1)

(c) The Indiana School for the Deaf: An educational institution for children who cannot make satisfactory progress in regular public schools because of a serious hearing deficiency. The institution offers education, care, and special disability-based training for children three (3) years old through high school age. Admission is by direct application to the school. (IC 16-33-2)

(d) Silvercrest Children's Development Center: Provides educational diagnosis, needs assessment, evaluation, short-term training and retraining of children with serious disabling conditions who cannot make satisfactory progress in public schools or special institutions of the state. Eligible children are those Indiana residents up to 22 years of age with 2 or more identified disabilities, whose physical care can be managed in the residential setting. The center will provide information, but admission is through the school corporation of the child's place of residence. (IC 16-33-3)

(2) Department of Correction Institutions for Children

The Plainfield Juvenile Correctional Facility and the Indianapolis Juvenile Correctional Facility serve a population of adjudicated delinquent children made wards of the Department of Correction (DOC) by the juvenile court. Once guardianship of the child is awarded to the DOC, juvenile court jurisdiction is discontinued. (IC 31-30-2) The expense of maintaining a child in either of these

facilities is shared equally by the county through the county general fund and the DOC.

Once a child has been dismissed from a correctional facility, wardship of the child does not automatically revert to the COFC. IC 31-30-2-2 requires the DOC to notify the juvenile court that awarded the guardianship of the impending release of the child from DOC custody at least 10 days prior to the release. The juvenile court has 30 days from receipt of such notification to reinstate jurisdiction over the child, on its own motion, in order to modify the court's original dispositional decree. Otherwise, probable cause warranting a CHINS petition would need to exist in order to reestablish jurisdiction.

(3) State-Operated Facilities: [State-Operated Facility: a state institution administered by either the Division of Disability, Aging and Rehabilitative Services (DDARS) or Division of Mental Health (DMH) of the Family and Social Services Administration (FSSA)]

FSSA emphasizes community-based services and the promotion of individual and family self-sufficiency. One of the objectives of FSSA is to enroll identified individuals in institutions into community-based services. All divisions of FSSA are to discuss and share information concerning a child on an inter-divisional basis before and during a child's admission to a state-operated facility. This is to ensure that:

(a) the state-operated facility placement is the least restrictive environment that can meet the child's needs;

(b) the child does not remain in a state-operated facility placement any longer than necessary;

(c) the transition of the child to the community is coordinated to meet the needs of the child; and

(d) permanency remains the major priority.

The State of Indiana operates several facilities through the Division of Mental Health (DMH) and the Division of Disability, Aging and Rehabilitative Services (DDARS). Some of these serve mentally ill children and some serve mentally retarded/developmentally disabled children. To access resources on behalf of mentally ill, mentally retarded, or developmentally disabled children with whom the COFC is involved and who meet the criteria for such services, the following procedures should be utilized:

(a) For assistance in obtaining treatment for a mentally ill child, COFC staff is to contact the area community mental health center (CMHC). Telephone numbers for CMHCs appear in the Family and Social Services Administration (FSSA) Service Entry Points listing by county in Appendix A of this section. Additional information concerning these centers can be found in Appendix B.

(b) For assistance in obtaining services for children relative to mental retardation (MR) and developmental disabilities (DD), contact the area Integrated Field Services (IFS) office, if the COFC is seeking family support services or residential placement for an MR or DD child. Do not contact a state developmental center directly. Telephone numbers for IFS offices appear in the FSSA Service Entry Points listing by county in Appendix A of this section. Additional information concerning IFS offices can be found in Appendix C.

(c) For assistance in obtaining only developmental or educational services rather than family support or placement services for children relative to MR or DD contact:

(i) the First Steps office, for children under three (3) years of age (See Appendix D for information regarding First Steps.); or

(ii) the local school corporation for children age three (3) through 18 or 21.

See Subsection 404.332 for further information regarding the role of the school corporation in obtaining appropriate services for special needs children.

The following is an outline of requirements, procedures, and responsibilities for placing agencies and state-operated facilities relative to the placement of children in such facilities:

(a) No child will be admitted to a state-operated facility (including education placements made through procedures outlined in Indiana's Special Education Rules 3-16, also known as "Article 7") unless the facility's admissions committee has met and recommended placement in the facility. The admissions committee must draft a discharge plan for the child before the child is admitted to a state-operated facility. For children whose placement is

not an Article 7 placement, upon admission, the child's records shall be reviewed for the appropriateness of Article 7 services.

(b) It shall be the responsibility of each state-operated facility superintendent to formulate procedures under which the admissions committee will operate and be incorporated into the facility's admissions process. The admissions committee's procedure shall be approved by the appropriate Division Director and, subsequently, by the FSSA policy staff.

(c) If the admissions committee determines that a child who is a CHINS should be admitted to a state-operated facility, the

county office shall do so on a voluntary basis in accordance with FSSA Policy AD 1-13, unless otherwise directed by the juvenile court judge.

(d) Once a child is admitted to a state-operated facility, the facility shall send a copy of all treatment team minutes or interdisciplinary team minutes, within the limits of applicable confidentiality laws, to the members of the child's admissions committee. Parents shall be notified and invited to attend all treatment team or interdisciplinary team meetings.

(e) For children who are CHINS, close contact between the child's home county family case manager and the facility are to be maintained. Copies of all treatment team meetings or interdisciplinary meetings are to be sent to the child's family case manager at least quarterly. The family case manager is expected to participate in treatment team meetings or interdisciplinary team meetings, as appropriate, to the maximum extent possible.

(f) The state-operated facility will be involved actively in the child's education and cooperate with the child's home school corporation and serving school corporation. If the child is in need of special education services, a state-operated facility representative will participate in the development of the child's Individual Education Plan (IEP). If the child is in need of special education services and is a CHINS, the child's home county family case manager must participate in the development of the child's IEP. If residential placement is identified by the IEP, the State Department of Education, Division of Special Education shall be contacted.

(g) When a state-operated facility and either a community mental health center (CMHC) or an integrated field service (IFS) office jointly determine that a child has reached maximum potential and is ready for discharge, all other divisions of FSSA are to work cooperatively to facilitate discharge. No division of FSSA is to block the discharge of a child from a state-operated facility.

403.12 Criteria for Selection

Below are some basic guidelines to consider when selecting an out-of-home placement for a child.

403.121 Relative and Foster Family Homes

Relative homes are to be given primary consideration when placement of a child is required. Relative and foster home placements typically may be most appropriate for the following children:

(1) Preschool-age children. Child caring institution and group home regulations prohibit the licensing of any facility for children under age six (6) unless a special waiver has been granted by the Central Office of the Division of Family and Children. Under no circumstances will a waiver be granted for a child under two (2).

(2) Sibling groups. Sibling groups are not to be separated if at all possible. If separate placements are made, a visitation plan must be developed and implemented within a specified time frame. See subsection 404.22.

(3) A child of any age who can accept and benefit from the closer relationship present in a relative or foster family home.

When possible, the legal family is to be involved in every step of the placement planning process. It is easier for parents to be supportive of the child's placement if they feel that they have had some choice and have had input in the placement process. This involvement of the legal parent also has been shown to have an impact on the child's positive adjustment in substitute care.

When considering foster family home placement for a child, the placement process must consider the child's special needs. These

might include, but are not limited to age, physical special needs, behavioral special needs, blood disorders; hearing, speech and vision impairments, cardiac disorders, developmental disabilities, emotional impairments, educational challenges, facial deformities, seizure disorders, and more restrictive placement. A "Special Needs Checklist" can be accessed in ICWIS in the Service/Case Management module. The use of the "Special Needs Checklist" helps to ensure that the child is matched with an appropriate family. The foster family with whom the child is matched is to be willing and able to meet the child's special needs. For foster family homes, the following types of placements are not advisable:

(1) Placement of more than the maximum number of children permitted under the definition of special needs or therapeutic foster family homes unless an exception is granted by the Division of Family and Children on a case-by-case basis.

(2) Placement of a sexually acting out child in a home with younger children or other children who are at risk of being sexually abused.

(3) Placement of an aggressive child in a home with younger children.

At the time the foster parent is contacted about accepting placement of a child, the family case manager shall share all known risk factors with the foster parent. If a child has been sexually abused, it is critical to share the circumstances of the maltreatment with the foster family, including the context of sexual abuse, location, duration, means used to gain the child's compliance, and relationship with the perpetrator. Refer to subsection 403.2, Preparation for Placement.

All relative and foster family homes must be licensed by the Central Office of the Division of Family and Children. See Section 6 - Licensing for additional information.

403.122 Institutions

Institutional placements may be considered for school-age children who present physical, mental, or emotional problems that are best treated in a group home or institutional setting. These children, particularly older ones, often have strong ties and loyalties to their biological parents that make it difficult for them to adjust to a substitute family. An institutional placement for a child is selected by matching the child's particular needs with the treatment program and specialized services offered by the institution.

All facilities used must be licensed by the Central Office of the Division of Family and Children except those which are operated

by another state agency such as the Department of Correction or Indiana Department of Health.

403.13 Local Coordinating Committees

According to IC 31-9-2-21, 80, 103, and 113 and IC 31-38, which was effective July 1, 1988, a local coordinating committee (LCC), hereafter also referred to as "committee", is established in each county. One purpose of the committee is to review restrictive placements whenever a referring agency proposing such a placement convenes a meeting of the committee. If the referring agency is the court, the COFC is to convene the meeting. **NOTE: The convening of a committee meeting by a referring agency to review a proposed restrictive placement for a child is optional. (IC 31-38-2-2)** When the committee receives a referral, the committee must make a recommendation as to the most appropriate placement and treatment plan. The committee is also charged to identify services that are needed but not currently available within the county.

403.131 Committee Membership

The LCC includes the following members:

Voting members:

(1) The Director of the county office of family and children, or the Director's designee.

(2) The director of the community mental health center or a managed care provider, as defined in IC 12-7-2-127(b), serving the child's area of residence, or the director's designee.

(3) The superintendent of the school corporation in which the child is legally settled, or the superintendent's designee.

Non-voting members:

(1) The child's parent or guardian.

(2) The child's guardian ad litem, if one has been appointed.

(3) The child's court appointed special advocate, if one has been appointed.

(4) A representative of the local health department, if requested by the chairperson.

(5) A representative of another agency or community organization, if requested by the chairperson.

Any member of the committee, voting or non-voting, may appoint a designee and shall grant the designee the same authority to commit agency resources, relative to participation on the committee as the appointing member has. The Child Protection Team in each county can serve as a local coordinating committee (LCC) provided that the agencies listed above are represented as specified. If a member of the committee appoints a designee, the designee shall have the authority to commit agency resources for the purpose of participating on the committee.

NOTE: The membership of the committee is to reflect persons specifically related to the child whose restrictive placement is under consideration.

A majority of the voting members of a committee constitutes a quorum. The committee may act only by an affirmative vote of a majority of the voting members present at the meeting. However, if a quorum of the committee cannot obtain a majority vote for any of the proposals or recommendations under consideration, the committee is required to report all of the proposals/recommendations to the referring agency.

403.132 Restrictive Placement

A restrictive placement is a residential placement of a child at a residence other than:

(1) the home of the child's parent, grandparent, sibling, aunt, uncle, cousin, stepparent or guardian; or

(2) a residence that is located in the child's county of residence and maintained by a person as that person's home.

This term includes foster placements located outside the county of the child's primary residence.

The LCC is not required to review the following restrictive placements:

(1) Predispositional detention, if a child is charged with a delinquent act as described in IC 31-37-1 through IC 31-37-2, not to exceed 60 days.

(2) Placement of a child in an in-patient psychiatric facility, not to exceed 30 days.

(3) Emergency placement in a shelter care facility, not to exceed 60 days.

(4) Hospitalization for purposes other than psychiatric care.

(5) Transfer of a child from one restrictive placement to another.

Restrictive placements which do not require review as listed above are treated as any other restrictive placement after the time limits set in this statute expire. It is the responsibility of the referring agency that placed the child under these provisions to inform the local coordinating committee (LCC) at least 15 days before the placement expires that the limits for the emergency placement will expire.

403.133 Referring Agency

Agencies that may make a referral to the committee for the purpose of reviewing a proposed restrictive placement include a:

(1) juvenile court;

(2) court having civil jurisdiction;

(3) community mental health center;

(4) county office of family and children;

(5) school corporation.

The referring agency is responsible to convene the meeting of the committee to review the proposed restrictive placement. The referring agency is to also:

(1) confirm that all pre-referral requirements have been met. This involves completion of the following forms:

(a) Referral Case Summary;

(b) Advisement to Parent/Guardian/Custodian;

(c) Release of Information.

See Appendix E for these forms and instructions. Although the Central Office of the Division of Family and Children made these forms available for use by the local coordinating committees, they are no longer available. Committees may continue to use copies of those forms or may develop others to meet their needs.

(2) provide voting and non-voting committee members with written summaries and reports including copies of family history, psychological reports and school reports five (5) days prior to the meeting. All materials should be stamped "CONFIDENTIAL".

(3) schedule the case review (time and date) and notify appropriate parties.

If the referring agency is the COFC, the family case manager who is assigned the case will be responsible for performing the above tasks.

If the referring agency is the court, the COFC is required to convene the meeting. All pre-referral information and documentation needs to be completed by the probation officer most familiar with the proposed placement. The Director of the COFC chairs the meeting in this case. At all other meetings, the chairperson is the voting member representing the referring agency unless the members of the committee agree on another method of selecting a chairperson.

403.134 Committee Responsibilities

Each local coordinating committee (LCC) shall:

(1) review any proposed restrictive placement that a referring agency brings to it by convening a meeting except those that are mentioned in section 403.132 of this section which do not require a review unless the time limits expire.

(2) consider alternative placements or treatment plans and make recommendations to the referring agency using the Committee Action Plan Form. (See Appendix H.)

(3) develop and recommend a long-range treatment plan for the child, including a treatment plan following the child's discharge from a restrictive placement. The Committee Action Plan Form is used for this purpose. (See Appendix H.)

(4) exchange information concerning services for children available in the county with members of the community, referring agencies, and other community organizations.

Proposed restrictive placements shall be reviewed by the committee before:

(1) the placement may be made; or

(2) the referring agency may submit its placement recommendation to the person authorized to make the placement.

If upon receipt of the case summary, the voting members agree unanimously that the referring agency has recommended an appropriate action plan including a discharge plan, a meeting

may take place by a conference call initiated by the referring agency.

403.135 Confidentiality

Unless prohibited by federal law, information concerning a child that is confidential to one referring agency may be disclosed to another referring agency on a "need to know" basis. See subsection 403.133 for a list of such agencies. However, the receiving agency shall treat that information as confidential.

Information that is confidential in nature may be discussed among members of the local coordinating committee (LCC) for each child. The members of the committee may discuss the child's information before, during, and after meetings. They may release this information to any person that will help in the completion of a treatment plan for each child in accordance with IC 31-38-2-7 and the guidelines for the particular agency using the information. Members of the committee may share the information with members of their own agency. Before members of the LCC may share this information, they shall weigh the benefits to each child and the necessity for sharing the information so that services may be rendered properly.

NOTE: For further information regarding the purpose, function and conduct of local coordinating committees, persons should review the manual- Opportunity: Indiana's Approach to Improving Opportunities For Multi-Needs Children.

403.2 Preparation for Placement

Children have feelings of loss, anxiety and confusion when removed from familiar surroundings and placed in an unfamiliar environment. Caregivers from whom the child is being removed may experience the same feelings. These feelings often are increased when faced with a lack of information regarding what will happen next and what action they may take relative to the situation. Having determined that a child is in need of placement outside of the home, the family case manager must prepare the child for the move to the fullest extent that time permits. Efforts are to be made as soon as possible to clarify the situation for the previous caregiver and, whenever possible, to involve the previous caregiver in the placement process in a positive way for the child's sake.

403.21 Preparation in Emergency Situations

Even in emergency situations, steps can be taken to lessen a child's anxiety and to facilitate the transfer of attachment to a new caregiver.

(1) The child is to be encouraged to take a familiar item to the new home.

(2) Every effort is to be made to ensure that siblings are placed together whenever possible.

NOTE: See subsection 708.23 for a full discussion of policy regarding preserving the sibling bond in placement.

(3) As much information as is appropriate for the child's age is to be shared with the child.

(4) Information regarding the home or institution to which the child is being taken is to be shared.

(5) The family case manager is to outline anticipated procedures affecting the child and the legal family, including time factors.

403.22 Preparation in Non-Emergency Situations

In non-emergency situations, whenever possible, the child is to be prepared by one or more pre-placement visits to the proposed new residence. Pre-placement visits are an especially important element in the ultimate success of placements in foster homes, residential child-caring facilities and group homes. This process affords the child the opportunity to become more familiar with the new setting and routine prior to placement, thus enabling the child to cope more successfully with the change. If possible, it is beneficial to enlist the cooperation of the birth parents to accompany the child at least to the initial visit. Such participation on the part of the parents serves to encourage the child to form a positive attachment to the new caregiver. The pre-placement visit also helps the new caregiver by giving that person an opportunity to become acquainted with the child before the child establishes residence. It is also an opportunity for the former and new caregivers to become acquainted and to form the groundwork for sound rapport and cooperation in future visitations.

403.3 Placement Policy/Procedures

The following is information regarding general out-of-home placement policy and procedures as well as procedures for placing children in out-of-county and out-of- state facilities.

403.31 General Information

For placement in any type of substitute care (i.e., a relative home, foster family home, group home, or child-caring institution), the following areas are to be defined clearly and understood by the COFC and the person(s) who is responsible for the care of the child:

(1) Case plan. (See subsection 306.63 for case plan requirements.)

(2) The role of the family case manager, relative caregiver and other members of the treatment team in the implementation of the case plan.

(3) Financial responsibilities.

(4) Frequency and conditions of parental visitation.

(5) Case review requirements.

(6) Time-limited goals of placement.

(7) The child's special needs and functioning in previous placements.

When the determination is made that a group home or institution would best meet the needs of the child, the COFC is to contact the director of the child-caring facility to make application.

403.32 Non-Discrimination in Placement Decisions

All recommendations regarding placements in foster care will be made to achieve permanency and on the basis of the child's specific needs and best interests and the ability of the caregiver(s) to provide the resources necessary to meet the child's needs. No placement in out-of-home care will be delayed or denied on the basis of race, color, or national origin of the caregiver(s) or the child in need of placement.

403.33 Preserving the Sibling Bond in Placement

Indiana recognizes the importance of the bond that exists between siblings, especially when they are taken into care and are separated from their primary caregivers. The bond between siblings is often the longest lasting relationship most people have, and these bonds help children develop their own unique personal identity throughout their lifetime. It is the responsibility of the DFC to maintain this sibling bond throughout the child's involvement with the agency whenever possible. This includes the time from the point at which the child is taken into care by the agency until after a permanency plan is developed and implemented.

403.331 The Importance of Placing Siblings Together

Biological siblings share the same genetic makeup. This becomes very important as children move into foster and adoptive families where they differ in appearance, medical predisposition, talents, and intellectual capabilities. When placed with siblings, they are less likely to feel isolated. Biological siblings share past experiences and family history. When children from dysfunctional families are placed in substitute care, a sibling is the only other person who knows how things were in the family of origin and the subsequent history of foster placement. Children need to integrate their past with their future in order to have continuity and to develop a clear understanding of their identity.

It is often difficult to find foster families who are able and willing to accept large siblings groups. It is the responsibility of the COFC to develop foster home resources sufficient to meet the

needs of large sibling groups. Often, there is a tendency to place siblings separately in foster and adoptive homes. There are, in fact, many families who are willing to foster or adopt groups of four or more children. It is the responsibility of the COFC to ensure recruitment and retention of these homes. Facilitating sibling placements might entail issuing a provisional license or waiver to accommodate an increased number of children in a home or searching for foster homes or facilities in other counties that will accommodate larger sibling groups. Again, it is the responsibility of each COFC to recruit and maintain families that are willing to foster or adopt sibling groups.

Children coming into care typically have troubled backgrounds, and this may result in moderate to severe behavior problems. When a sibling is removed from a home because of behavior problems, the remaining children may feel that the same thing can happen to them. This reduces their sense of trust in their caregivers.

Siblings are often separated when one is victimizing another. Separating the siblings does not guarantee that the abuse will not continue in another home. Therapy, with a safety plan in place, may be an appropriate intervention. In all instances, these circumstances are to be brought to the attention of the court.

The complex bonds linking brothers and sisters are universal and among the most important in life. They become even more important as we age. In the final analysis, sometimes sibling relationships may be all that remain of the family of origin after foster care placement. These relationships form the blueprint for later relationships with peers, friends, marriage partners, and their own children. Siblings who remain together learn how to resolve their differences and develop strong relationships.

403.332 Policy Regarding Placing Siblings Together in Out-of-Home Care

The reasons for siblings being separated when placed in out-of-home care are many and varied. However, the policy of the Division of Family and Children with regard to the placement of siblings in out-of-home care is as follows:

In the absence of a strong reason to the contrary, groups of siblings are to be placed together whenever possible in order to maintain existing ties and supports and to minimize the degree of loss to the children. Therefore, it is Division policy that children who are not initially placed together have contact within 48 hours (excluding weekends and holidays) of placement. It is also the policy that children are to be placed together within 10 working days. An exception to this policy would occur when one of the

children is in residential placement, hospitalized, or in a juvenile detention center. Nevertheless, efforts are to be made for children to have ongoing contact.

While it is often not possible to place siblings together immediately when they are taken into care, it is important that siblings be reunited as soon as possible. The same policy is to apply when additional siblings are taken into substitute care at a later date. When children from the same family are wards in two or more different counties, it is the responsibility of the Directors of those counties to initiate a visitation plan.

If parental rights are terminated on a child or the permanency plan for a child is adoption, and if the child's sibling(s) is in a pre-adoptive placement, the family who has the sibling is to be approached about accepting the other sibling(s). In the event of previously finalized adoptions, the adoptive parents of those children are to be approached regarding the placement of new siblings free for adoption. The emphasis continues to be on the child's essential connections and respecting the power of those connections in achieving a successful adoption for the child.

403.333 The Decision to Separate Siblings

Separation of siblings requires as careful consideration as severing parent-child attachments. Any decision to separate siblings before, during, or after placement must be handled as an exception to policy.

The following guidelines are to be followed:

(1) Keep the focus on the best interests of the child and on permanency.

(2) Never make the decision alone. Include the court, current and former caregivers such as foster parents, therapists, supervisors,

counselors, guardians ad litem (GALs), court appointed special advocates (CASAs) and any others who have played an important role in the child's life.

(3) Consider the child's wishes as part of the decision-making process.

(4) Document all of the reasons for and against separating the children. Making a list will force an examination of the pros and cons. Provide clear documentation of the circumstances leading up to the decision.

(5) Special attention must be given to any sibling relationships known and remembered, and even unacknowledged ones

are to be explored in terms of their later developmental impact on children in care.

(6) If separation is necessary, efforts are to be made to help all the children involved understand and grieve for the loss.

(7) The plan to separate is to be supported by a specific, concrete plan for future contacts between the children.

403.34 Out-of-County Placements

Whenever possible, placement is to be within the county having responsibility for the child. The COFC is to have a sufficient number of licensed foster homes to accommodate the number of children in the county who are in need of this type of placement. Nevertheless, it may be necessary to use an out-of-county resource. Out-of-county placement resources are subject to the same Central Office requirements regarding licensing and service delivery as those within the county. Placement in an out-of-county resource may be reviewed by the local coordinating committee, if the placement is more restrictive than the environment that the child is currently in and if the referring agency convenes a meeting concerning the proposed placement. See IC 31-38.

If the county in which the child resides is in need of an out-of-county foster home, assistance in locating such a home may be obtained from other county offices of family and children (COFCs) and child placing agencies. If a prospective foster parent contacts the local office in the foster parent's county of residence with a request to provide care for a child in another county, the local office receiving the request should notify the COFC in the child's county of residence of the inquiry. If an out-of-county resident directly contacts the COFC in the child's resident county and expresses interest in providing care for the child, that local office must contact the COFC of the applicant's residence to secure permission to use the home. Use of the home is inadvisable if the local office in the applicant's resident county recommends the home not be used. The COFC placing the child is responsible to set the appropriate per diem based on the child's needs. Refer to subsection 615 for further information regarding the use of out-of-county homes.

NOTE: Family case managers are to document information regarding out-of county placements on the Restrictive Placement screen that is accessed from the Placement Details screen.

403.35 Out-of-State Placements

See Section 5 of this manual.

403.4 Special Considerations Regarding Foster Family Home Care

The following subsections contain policies concerning issues that are specific to foster family home care:

403.41 Personal Characteristics to Look for when Assessing Potential Foster Parents

Foster parents are to be persons who:

(1) care about others and respond appropriately;

(2) enjoy being parents;

(3) are able to give affection and care to a child without expecting immediate returns;

(4) demonstrate flexibility in their expectations, attitudes, and behavior in relation to the age, needs, and problems of children, as well as an ability to use help when needed to address problems of family living;

(5) have sufficient energy, mental and physical stamina, and patience to cope with the demands of a child who is experiencing the loss of a parent and the insecurity of a new living arrangement;

(6) are able to acknowledge the child's relationship with the child's parents and with the agency;

(7) have worked out satisfactory and stable adult relationships, are comfortable with their own sexual identity, and are able to model and exemplify stable adult relationships;

(8) are able to identify and handle strong feelings, including anger, depression, and loss;

(9) are able to maintain meaningful, positive relationships with members of their own families and with persons outside the family;

(10) are emotionally stable and able to function adequately in relation to family responsibilities and employment, as indicated both currently and in the history of the family;

(11) have reputable characters, values, and ethical standards conducive to the well-being of a child; and

(12) are able to accept the temporary nature of foster care and assist the Division in permanency planning for a safe, secure permanent future for the child.

403.42 Responsibilities of the Foster Parent

The following constitutes a breakdown of the responsibilities that individuals assume when they become foster parents:

(1) General responsibilities include:

(a) giving love, acceptance, and care to a child without expecting a demonstration of appreciation from the child;

(b) providing the child with opportunities for normal growth and development;

(c) assisting in preparing the child for reunification or permanent placement;

(d) maintaining confidentiality as it relates both to the child and the child's family;

(e) encouraging the child toward independence and self-reliance in age-appropriate ways;

(f) providing input into the child's case plan and needs.

(2) Responsibilities to the child include:

(a) providing a safe and warm environment;

(b) modeling adequate parenting skills and demonstrating healthy behavior;

(c) making a commitment to keep a child for a planned period of time;

(d) providing understanding and emotional support to the child as it relates to the separation trauma the child is experiencing;

(e) giving support related to: school and academic achievement, extra-curricular activities, church and religious involvement, and arranging or providing for transportation needed to be a part of these community activities.

(3) Responsibilities to the foster child's legal parents include:

(a) presenting a positive image of the legal parents to the child;

(b) cooperating with visitation between the child and the child's legal parents;

(c) being a temporary substitute, but not a replacement, for the child's legal parents.

(4) Responsibilities to the agency include:

(a) complying with the general supervision and direction of the agency concerning the care of the child;

(b) helping in establishing a case plan and then working to implement the plan;

(c) keeping records of important issues related to medical, school, social, and family matters that would be of interest to the agency;

(d) being willing to cooperate with community support services that may be available;

(e) participating both in pre-service and in-service training as determined by the agency.

(5) Additional personal responsibilities include:

(a) being aware of community support and resources to meet both personal and social needs;

(b) being aware of local, state and national support groups;

(c) knowing oneself and being aware of personal strengths and limitations;

(d) using respite care, family support or day care as a means of reducing long-term stress.

403.43 Responsibilities of the Division

The following constitutes the responsibilities the Division assumes when placing children in a foster home.

(1) Reasonably assist the foster parents in securing and maintaining their foster care license issued by the Division of Family and Children, including the provision of required training, while treating the foster parents with respect and appreciation.

(2) Provide a copy of current licensing rules of the Division and written guidelines of the COFC or LCPA and ensure compliance with the written requirements as they apply to foster care.

(3) Provide an explanation of the division's policies on discipline, matching, foster parent role, visitation and the division's role and responsibility.

(4) Provide an explanation of the Division's case conferencing policy which operates on the basis of shared and clarified information between the COFC and foster parents and requires the involvement of the foster parents in case plan development and change. This policy also includes a methodology for resolving conflicts between foster parents and the COFC. See subsection 403.47.

(5) Provide foster parents with the names and phone numbers of foster care family case managers and a copy of the Division or LCPA

policies and procedures related to notification, including a plan for emergency "after hours" contact.

(6) Provide information, education and training on cultural awareness and promote cultural and minority sensitivity.

(7) Provide information regarding a child's religious preference.

(8) Provide foster care per diem, clothing allowance and necessary dental and medical expenses including eye care and arrange any other special medical or psychological services.

(9) Secure the proper authorizations for the administering of any non-emergency treatment to the child, and consult with and assist the foster parents in providing treatment or referring them to an appropriate service provider.

(10) Provide an allowance for education needs including tuition, supplies, rental fees and any approved fees for supplemental education. This may or may not be a part of the per diem to the foster home. County expenditures are limited to education in public accredited schools.

(11) Develop a case plan for each individual child in foster care, seeking input from the parents, child, and foster parents. The plan is to be shared with the so that they are familiar with the case goals and specific needs of each child placed in the foster home.

(12) Provide a copy of SF 45001 Case Plan II (Child Information/Service Plan for Substitute Caretakers), which defines appropriate foster care for the individual foster child related to such aspects of foster care as discipline and visitation for a child in foster care.

(13) Assist in arranging visitation, and encourage communication between the foster children and their parents or other individuals. The COFC will provide such notice as is proper to the foster parents under the circumstances.

(14) Monitor and supervise the implementation of the case plan, making face-to-face contact at least once every two (2) months with the child and the foster parents or as the case dictates.

(15) Consider input from foster parents and other appropriate persons, and make final decisions concerning the care and well-being of foster children, within the legal framework established for the Division.

403.44 Role of the Division

The agency role in the placement of children in foster family care is multi-faceted. The legal relationship the Division has is sanctioned by the juvenile court relative to the foster child and by the Indiana statute governing the

licensing of foster family homes relative to the foster parents. Beyond the legal role/relationship, the agency staff must facilitate a team effort with the child's parents, foster parents and service providers to meet the needs of the foster child and provide a permanent plan for the foster child relative to all service programs.

The team approach requires agency staff to ensure that communication among team members remains open and that information sharing will result in a well thought out plan that ensures a family-centered, child-focused approach to family service delivery. See subsections 403.452 and 403.46 for additional information concerning conflict resolution among foster care team members.

403.46 Role of the Foster Parent

Foster parents play multiple roles relative to placement issues. The following constitutes a delineation of those roles:

403.451 As a Team Member

Foster parenting is the provision of a substitute family for a child who has to be separated from the legal parents. Such a placement is temporary and is planned to encompass a specific period of time. If reunification with a child's own family is not possible within prescribed time frames, foster families provide care to the child in transition who is preparing for a new permanent family.

Foster parenting involves two simultaneous roles: parenting and substitute parenting. The parenting tasks require general child care, which any birth parent would provide. The substitute parenting tasks require a commitment to permanency planning, and involve working in partnership with the agency, court, legal parents, and adoptive parents.

Foster parents enter into a partnership with the COFC staff to be part of a team that will work together to develop a permanency plan for each child. The dictionary defines teamwork as the "cooperative effort of an organized group to achieve a common goal." As applied to foster care, the team's goal is the protection of children while developing and implementing a plan for permanency.

The team approach requires the cooperation of members who have interdependent skills and differentiated knowledge. It encourages the development of individual expertise and provides more points of view upon which to base sound decisions. Difficulties arise when there is a lack of commitment to or clarity about the goal and when overlapping tasks create confusion. "For the team process to work effectively, it is crucial for team members to know each other and develop ongoing relationships which foster trust and mutual respect. Since members must make difficult decisions,

it is important that they understand each other's personal and professional perspectives. Members must also be able to define and articulate their professional role on the team". (Ziefert and Faller, 1981).

403.452 In Reunification

The option of choice for permanency for the child is reunification with the child's legal parents when it is believed to be in the best interests of the child and when it provides protection for the child. While child welfare services are focused on the family as a unit, the primary concern is the best interests, health and safety of the child. The role of the foster parent, when reunification is the goal, involves a partnership between the Division and the foster parent to the extent that the foster parent is a contributing member of the child welfare treatment team. With appropriate training, encouragement, and support, foster families can become a substantial resource in enabling the child's parents to resume their legal responsibilities to the child and in fostering the return of the child to the legal family. Rather than competing with legal families for the child's affection, foster parents are to be a source of emotional support for the legal family, a model of healthy family relationships, and a source of parenting expertise.

The foster family's concern and support for a child's family increases the legal family's self-esteem, reinforces their efforts toward return of the child, and models specific behaviors. Perhaps most importantly, cooperation between legal and foster families provides a more consistent emotional environment for the child that tends to eliminate situations that confuse the child as to whom the child should love or with whom the child should identify.

(1) Tasks

There are several tasks that foster parents are to keep in mind when working with the legal family. They are:

(a) maintaining confidentiality of case information;

(b) respecting the legal parents and their right to their child;

(c) understanding the importance of the legal family to the child;

(d) cooperating in carrying through with visitation plans;

(e) cooperating with the worker and other team members;

(f) understanding the dynamics of loss and separation as it pertains to the child and the legal parents;

(g) maintaining knowledge of community resources.

(2) Specific activities

Specific activities related to the foster parent's role in working with the child's legal parents include:

(a) teaching or modeling appropriate behavior and parenting skills;

(b) sharing in decision-making with the legal parent and the agency;

(c) including legal parents in special events such as school conferences, birthdays, holidays, as appropriate;

(d) helping the child find ways to express love to the legal family (gifts, writing letters);

(e) seeking information from the legal parent regarding the child's progress in reconnecting with the legal parent;

(f) maintaining active communication with the family case manager;

(g) assisting in planning visitation, including planning for transportation for the child;

(h) facilitating an atmosphere conducive to quality visits and suggesting visitation activities which are related to the child's developmental age (Legal parents should be encouraged to become involved in child care tasks.);

(i) attending permanency planning meetings;

(j) documenting progress and significant events involving the legal parent-child relationship.

403.453 In Adoption

Each child is to have a permanent family in which to grow up. When that family cannot be the child's parents, adoption by relatives or non-related persons is the preferred plan, since adoption gives the child a new set of legal parents. The following information defines the tasks of the foster parents

based upon the assumption that the foster parents are not interested in adopting the child in their care.

(1) Tasks

The foster parent's tasks relative to adoption include:

(a) working cooperatively with the agency to identify potential adoptive parents who can meet the child's needs in the best possible way (This statement assumes that the foster parents have chosen not to attempt to adopt the child in their care.);

(b) helping prepare the child for this very important change in the child's life.

(2) Specific activities

Specific activities related to the foster parent's role in adoption include:

(a) working cooperatively with the family case manager to explain to and discuss with the child what adoption means;

(b) listening to the child's feelings (fears, anger, uncertainties) about what is going to happen to the child;

(c) being honest in telling the child why the foster parent cannot adopt the child and listening to the child's feelings about that;

(d) preparing the child for the possibility of being photographed or of talking with new family case managers who will be helping to find the right family for the child;

(e) giving complete and accurate information to the family case manager so that the family case manager can provide accurate information about the child and find the best home for the child;

(f) assisting the family case manager in planning visits with potential adoptive families and preparing the child for these visits in cooperation with the family case manager;

(g) watching the child's reactions and behaviors; being patient and sympathetic with the child during this difficult time, and continuously providing information to

the family case manager regarding the child's feelings, reactions, and behaviors;

(h) finding someone to help with personal feelings as the child leaves;

(i) giving the child permission to become attached to adoptive parents and sharing information and experiences related to the child's placement in the foster family home with the adoptive parents;

(j) helping the child prepare for visits with birth family/siblings to say good-bye, in cooperation with the family case manager;

(k) preparing or helping the child prepare the child's belongings, life book, and important papers to make the move to the adoptive home (See subsection 404.6 for additional information regarding life books.);

(l) cooperating with the agency and adoptive parents as agreed following the placement of the child.

403.454 In Providing Independent Living Skills

Older foster children eventually come to the point when they must move out of their protective foster family environment and make it on their own. This usually occurs at age 18, unless they are allowed to remain in foster care for educational purposes or because they have a disability. If they have not been prepared, formally and informally, they will not survive in a productive manner. Foster families must be a part of the process that teaches as many independent living skills as possible to each child, regardless of whether the child will return home or choose to live independently.

Foster families must work with the agency to provide formal or informal training in independent living, and they must be aware of the issues that face each child when the time comes for the child to leave the home.

(1) Tasks for All Foster Parents

The tasks of foster parents of any foster child relative to independent living include:

(a) understanding the importance of each child's case plan as it pertains to independent living;

(b) having a basic understanding of child development;

(c) working with the family case manager or service provider to assess the child's daily living skills;

(d) working with the family case manager or service provider to establish goals for daily living skills; i.e., chores, personal care, independent living skills.

(2) Tasks for Foster Parents of an Adolescent

The tasks for foster parents of an adolescent foster child relative to independent living include:

(a) performing all tasks listed in (1) above; and

(b) advocating for the child to receive formal services for independent living;

(c) taking advantage of opportunities to learn about issues in independent living, what the child's needs are, and what independent living programs are available;

(d) being aware of community resources for the child; i.e., church, school, government, and community agencies;

(e) helping the child to build support systems; i.e., friends, family, college, military service, community groups;

(f) allowing the child to verbalize positive and negative feelings about leaving. The child may resist services to emancipate.

(3) Specific activities

Teaching independent living skills must be a process that is implemented for all youths in substitute care, regardless of their possible future living arrangements. Independent living skills can be divided into tangible and intangible skills as listed below:

TANGIBLE SKILLS	INTANGIBLE SKILLS
Educational skills	Decision-making
Vocational skills	Problem-solving
Job search skills	Planning
Money management skills	Communication
skills	

Home management skills	Interpersonal relationships
Consumer skills (taxes, insurance)	Time management
Community resources	Self-esteem
Transportation	Confronting losses, anger, rejection
Health care	Social skills
Understanding laws	Emotional preparation for transition to independent living
Obtaining housing	

403.46 Placement Disruptions

Disruption in a child's placement must be considered carefully, because it has the potential to jeopardize the child's capacity to trust the environment, including the adults around the child. Disruption can have serious negative consequences for the child's sense of security and self-worth. The decision-making process must include not only an evaluation of the factor(s) immediately precipitating the planned move, but also an analysis of the historical overview of both the child and the foster family. The specific issues that are to be addressed are:

(1) the age of the child and the child's capacity to understand the reasons for the removal;

(2) the emotional connections between the child and the foster parents;

(3) the length of time that the child has resided in the current placement;

(4) the number of prior placements;

(5) the child's ability to reattach and to adjust to a new environment;

(6) the availability of a suitable alternate placement and the risk of future disruptions;

(7) the child's concept of the child's own essential connections;

(8) Child Protection Services intervention;

(9) the foster family's history with the agency as it relates to cooperation and the ability to endure/resolve problems, and the family's history with other foster children;

(10) any mitigating factors in the foster family home which contributed to an isolated incident or deteriorating conditions such as temporary over-crowding, stress, medical or financial problems, physical and dependency needs of young children, severe behavior problems of birth or foster children, or the inappropriateness of the placement;

(11) the availability of support services to the foster family; i.e., homemaker, child care, respite care, and counseling services;

(12) the willingness of the foster family and child to join with the COFC in developing and implementing a corrective action plan;

(13) the child's personal view of why disruption is needed or desired;

(14) whether the removal is an emergency or non-emergency.

403.461 Types of Removal

Despite our best efforts to avoid it, removal of a child from a foster family home for reasons other than the reunification of the foster child with the legal family, adoption, or implementation of another permanency plan sometimes becomes necessary. The following delineates procedures to be used in various types of removal.

403.4611 Emergency Removals

Although, legally, the COFC family case manager may remove a foster child with or without the foster parents' consent, it is advisable for the family case manager to make every effort to secure the cooperation of that foster parent. See subsections 403.462 and 403.47 below for more information regarding resolving disagreements between the COFC and foster parents. However, a child must sometimes be removed from a foster home on an emergency basis due to the inability of the COFC to ensure the safety and well-being of the child. The need to ensure safety and well-being supersedes reaching consensus with the foster parents. If the foster parents attempt to physically prevent a child's removal, the family case manager is to request the assistance of law enforcement or obtain a court order if necessary.

403.4612 Non-Emergency Removals

In some instances, foster parents may decide that circumstances call for a cessation in participation in the foster parent program or that they are no longer able to meet the needs of a particular foster child. Therefore, they request removal of the child(ren) on a non-emergency basis.

In other instances, the COFC may determine that while the child is not at imminent risk, the best interests of the child might be better served

through a change in placement. The factors listed below may influence such a determination.

(1) There is clear evidence that:

(a) the foster family ostracizes or segregates the foster child from normal foster family activity, despite attempts to encourage change.

(b) the foster family continues to make inappropriate or derogatory remarks about the child or about the child's family, despite repeated attempts by COFC to encourage the family to express more positive attitudes.

(c) the foster parent continues to use ridicule, threats, rejection, or other words or actions, such as breaches of confidentiality, which are emotionally damaging to the child, despite repeated attempts by the COFC to encourage the foster parent to treat the child more appropriately.

(d) the foster parent has demonstrated a pattern of interfering with or subverting the goals of the case plan.

(e) the foster parent has a pattern of violating agency policy, despite attempts by the COFC to encourage compliance with policy.

(2) The foster parent disagrees with the case plan and pursues an independently developed case plan without first attempting to resolve the disagreement with COFC through more appropriate channels.

(3) The foster parent and the COFC have determined that the placement is not in the best interests of the foster child or the foster family. However, the foster family has not given the COFC the requisite two (2) weeks notice prior to the child's removal. This would classify the removal

as a non-emergency, unless the foster parent feels that
conditions require the child's immediate removal or unless the court orders emergency removal.

Requests for non-emergency removals may be initiated by the foster parent or by the child. Procedures for each situation are outlined below:

(1) Non-Emergency Removals - Foster Parent's Request

Two (2) weeks notice must be given to the Division by the foster parents prior to any removal. Such notice is critical to ensure adequate opportunity to make suitable alternate arrangements for the child. No request by the foster parents for a child's removal is to be dismissed from attention, even if the foster parents change their minds and decide to keep the child. The request to remove the child may be a signal that the family has problems and that services should be considered.

Whenever foster parents request that a child in their home be removed, the family case manager must determine the reasons for the request. The family case manager must note in the contact log those reasons that have been cited by the foster parents as causing the placement change request. The child's level of understanding, reaction, and desires should also be noted in the contact log. This information, whether or not a placement disrupts can be useful in developing a foster care plan for the foster placement, as well as providing information that is useful in the ongoing life book process. See subsection 404.46 regarding life books. Based on the foster parents' explanation, the family case manager may suggest appropriate support measures such as therapy, respite care, child care, temporary homemaker services, or emergency financial assistance that might ameliorate some of the presented problems.

The family case manager is to schedule a personal meeting with the foster parents to further discuss the potential disruption. If

the foster parents remain firm in the desire to have the child removed, the family case manager is to initiate a change of placement request with the foster care case manager within one (1) working day. Also the family case manager is to schedule a meeting with the foster parents and child to discuss the placement change, family issues, the child's reaction to and understanding of the move and the future emotional/psychological implications of the move to the child.

There are some occasions when a child must be removed from a foster home as soon as possible, despite the agreement to provide two weeks notice for a removal. The following occasions may require earlier removal:

(a) The child is believed to be at risk of serious physical or emotional harm if allowed to remain in the foster home, whether or not the belief is based upon Child Protection Service intervention.

(b) The foster family is, or perceives itself to be, at risk or harm if the child is allowed to remain in the foster home.

(c) The foster family has experienced a personal emergency and is unable to make alternative plans for the child.

Procedures for Foster Parent Requested Removal

Responsibility : Action Required

Foster Parents: Tell family case manager that they want child removed and why.

Family Case Manager: Explore services with foster parents that might alleviate need for a placement change.

Schedule home visit to discuss move with child, if child is at age of understanding, giving consideration to child's mental capabilities and mental health. Also discuss move with foster parents.

Schedule date for child's anticipated removal, if foster parents see no other way to help maintain the placement (two weeks notice).

Initiate placement change; give information to foster care placement case manager, if applicable.
Family Case Manager and Foster Parent: Help child resolve any feelings about the move.

Foster Parent: Give child photo of foster family and of child in their home and any other items or information for life book.
Go through child's clothing list to see if clothing still fits and is in good condition.
Send all personal belongings, including clothing, with the child.

(2) Non-Emergency Removals - Child's Request

A request by any child to leave a foster home placement must be considered very seriously. However, a child who indicates discomfort in a particular foster home may, in fact, be talking about other, more critical issues. When the family case manager discusses a requested move, the following possibilities are to be considered:

(a) The child's request may be attributable to the stage of placement.

(b) There are underlying problems in the foster placement about which the child feels uncomfortable verbalizing, such as sexual abuse, physical abuse, neglect,

harassment, emotional abuse or neglect, sibling problems or prejudicial treatment.

(c) The child believes that a disruption of the foster family home placement may result in a return to the birth parent or a return to a former family to whom the child feels attached.

(d) The child has had a recent disagreement with a member of the foster family, and the request is reactionary.

(e) The foster child is intimidated, harmed by, or in some way disturbed by the physical environment, including neighborhood, home, or school and does not know how to deal with the difficulty.

(f) The child has a history of frequent moves and resists any family with whom an attachment might be formed.

The family case manager is to determine through a personal interview if there are any underlying reasons for the child's request to leave the foster home. If the child requests that the information conveyed during the interview be kept confidential, the family case manager is to make a decision based on both respect for the child's right to privacy and any need or requirement to share the

information. In some instances, the child is to be advised that the problem cannot be resolved if the confidence is kept.

If the family case manager suspects that the child may be at risk, the child is to be removed immediately. If the child does not appear to be at risk, the child is informed that a decision about removal will be made within five (5) working days. The family case manager must respond with a decision directly to the child and not via any other

member of the foster family. It is essential to encourage the child to engage in open, forthright conversation with the foster parents to resolve problems. The family case manager may need to facilitate this discussion.

The family case manager must first discuss every removal requested by a child with the family case manager's supervisor, the foster parents, and the guardian ad litem (GAL) or court appointed special advocate (CASA), if one has been appointed, prior to making any decision unless emergency removal is warranted. The family case manager is to record in the child's case record the results of the interview with the child, other consultations, and the final determination. If the decision is to remove the child, the family case manager initiates the removal process. Otherwise, the family case manager is to explain the decision to the child and attempt to resolve the child's difficulty. If the child remains adamant about leaving, the child may request a conference with the family case manager, supervisor, and the CASA representative. However, the child must agree to continue in the current foster home pending the conference. The child may withdraw the request for conference at any time. The conference is to be scheduled within 10 business days, and all parties are to be advised of the conference; i.e., the family case manager, the family case manager's supervisor, and the CASA representative.

Procedures for Child Requested Removal

Responsibility / Action Required

Child: Advise family case manager of desire to make a change in placement.

Family Case Manager: Respond to any request by the child for confidentiality, either indicating that the confidence can be kept or that the resolution of the problem requires that information be shared.

Attempt to assess the underlying causes of the child's request to move.

If the child appears to be at serious risk of abuse or neglect, the child is to be removed immediately. See subsection 403.21. If there appears to be no immediate need to remove the child from the foster family home, discuss child's request with the supervisor and the foster parents to determine whether removal is in the child's best interests.

Encourage child to talk to foster parents regarding problem.

Help child resolve any feelings about the move.

Request a conference with case manager, supervisor, GAL/CASA representative and foster parents, if advisable.

Foster Parents: Help child resolve any feelings about the move.

Give child photos of foster family and of child in their home as well as other personal items or information for life book.

Go through child's clothing list to see if clothing still fits and is in good condition.

Send all personal belongings, including clothing, with the child.

403.462 Disagreement with Removal or Proposed Removal

In all instances, the primary responsibility of the COFC is to ensure the safety of the child and to promote the child's best interests. For non-emergency removal decisions, it is incumbent upon all of the principals, current caregivers, and appropriate agency representatives to try to resolve disagreements prior to removal and before a court hearing. However, there are times when a child must be removed without first obtaining consensus between the COFC and the foster parents regarding the move. Nevertheless, an attempt must be made to resolve outstanding issues to the extent possible.

403.47 Enhancing Communication with Foster Parents

It is the goal of the Division and foster parents to ensure the safety of the child in out-of-home care while developing a permanency plan. When the

safety of the child is felt to be at risk, the usual process for investigating all allegations of abuse or neglect will be followed. Any child protection service (CPS) ruling will take precedence over any attempt to reach consensus with foster parents regarding decisions made during the CPS investigative process. In addition, decisions of the court will supersede any and all other agreements made by any other parties.

In all situations other than those defined above, it is important to achieve consensus, if at all possible, between DFC and foster parents for the benefit of the child's well-being. In a continuing effort to enhance the working relationship between the DFC and foster parents, the policy directive outlined below is to be followed. It is designed to identify those occasions when the input and participation of the foster parents are expected and required for the purpose of establishing consensus on what is in the best interest of the children in care. The DFC and foster parents, working together, can build and support a safe environment in which information will be shared and valued.

403.471 At the Local Level (Case Conferencing)

Foster parents and family case managers are to work together on the basis of shared information, adequately clarified for all parties, as far in advance as possible. This is especially important with regard to anticipated changes in placement. Foster parents are to be included in the development and changing of the case plans for the children in their care.

Foster parents must first try to resolve issues by discussing them with the appropriate family case manager. Issues involving parenting or licensing practice are to be discussed with the foster family's licensing case manager. See Section 6-Licensing for further information. Issues involving the foster child's case plan or removal from the foster family home are to be discussed with the child's family case manager.

If the foster parent does not agree with the family case manager's response to the issues, the foster parent may contact the family case manager's supervisor. If the foster parent is not satisfied with the supervisor's response, the foster parent may contact the COFC Director. The foster parents may contact a representative of the Indiana Foster Care and Adoption Association, Inc. (IFCAA) and/or another foster parent or foster care provider to attend this meeting. Such a representative is to be available to the foster parent as a source of consultation and advice, if requested. The child's family case manager and/or the licensing family case manager may also attend.

If, after following these steps, issues remain unresolved, a formal case conference is to be convened. However, if the unresolved issue is removal of the child from the foster family home and the safety of the child is at risk, removal is to occur prior to a case conference. As previously stated, if the safety of

the child is felt to be at risk, the usual process for all allegations of abuse or neglect is to be followed; and any CPS ruling will take precedence over any attempt to reach consensus between the COFC and foster parents. Court rulings also supersede consensus-building endeavors. A case conference is not required if the foster parents and COFC staff are in agreement about the placement and removal of a child.

The COFC, foster parents, or guardian ad litem (GAL)/court appointed special advocate (CASA) may request a case conference. The staff of the COFC is to arrange the conference and notify parties of the meeting within five (5) working days following the request for a conference. The case conference is to convene within 10 days and is to be held in the COFC or other location agreed upon by the parties.

The core group of the case conference is to include such COFC staff as the family case manager or supervisor, and foster parents, legal parents/legal guardians, the GAL or CASA; and the child, if appropriate. In addition, teachers, counselors, and other persons having knowledge or relevant concerns regarding the situation under consideration may be invited to attend by any member of the core group.

An informal case conference may be held when it is not practical to convene the entire committee. This may be done by phone or with individual meetings. However, each person on the committee must be contacted; and the contacts and recommendations must be documented by the family case manager in the contact log. An informal case conference may not be utilized when developing or changing the case plan or when there is disagreement about the removal of a child from a foster home.

NOTE: If at any time any member of this core group feels that the policy of the Division is not being followed, the Director of the COFC is to be contacted. If the foster parent is still concerned that policy is not being followed, the Central Office of the Division of Family and Children Foster Care Consultant is to be contacted at (317) 232-7116. This contact may be made either by the foster parents or the Indiana Foster Care and Adoption Association (IFCAA) representing the foster parents.

If the core group cannot reach consensus concerning a recommendation to the court, the COFC Director will review the case and try to bring the group to consensus. If the foster parents are still not in agreement with the decision, the matter can be taken through the Communication Enhancement Procedure. See subsection 403.472 below.

403.472 At the Regional Level (Communication Enhancement Procedure)

In building a foster care team, it is essential that there be viable communication between foster parents and the county office of family and children (COFC) staff. However, there will be times when conflicts or disagreements arise between these parties that cannot be resolved at the local level.

If the issue cannot be resolved at the local level, the foster parent is to request a review of the issue by the Regional Communication Enhancement Procedure Committee (RCEPC). This request shall be in writing and addressed to the Regional Manager or designee (name and address to be provided by the county Director).

A Regional Foster Care Communication Enhancement Procedure Committee is to be comprised of the following persons:

(1) the COFC Director or designee;

(2) a family case manager or supervisor;

(3) two (2) licensed and/or approved foster parents; and

(4) a community representative.

The Director and the family case manager or supervisor, when practical, are not to be from the same COFC, and the foster parents are not to be licensed and/or approved through the same COFC. The community member may be a member of the Local Coordinating Committee or local Child Protection Team but is not to be a current or former agency staff person or foster parent. However, this member is to be knowledgeable regarding child welfare and foster care issues. The Regional Manager shall appoint all members of the RCEPC after receiving the recommendation of the Regional Child Welfare Executive Committee.

All members of the RCEPC must be willing and able to commit a minimum of one (1) year to serve on this committee. The Regional Manager (or designee) shall assess the RCEPC membership annually regarding effectiveness and continuing membership. Each RCEPC is to be available to meet on a monthly basis.

Upon receipt of a written request from a foster parent for review by the RCEPC, the Regional Manager is responsible for convening a meeting of that committee. If the issue for review concerns the placement or removal of a child in the foster home, the RCEPC must meet within 10 working days of receipt of the written request. All other reviews must be held

no later than 30 days after receipt of the written request. The regular communication enhancement procedure will be utilized and adhered to as outlined in the Foster Family Handbook.

The foster parent may wish to be accompanied by another foster parent when attending this review. A member of the Indiana Foster Care and Adoption Association, Inc. may be available, if requested, for support and advice. The Director of the county office of family and children will determine who presents the Division's information.

A majority vote of the members of the RCEPC shall constitute the decision of the Committee. If the RCEPC is unable to reach a majority decision, the Regional Manager shall cast the deciding vote. The majority decision of the RCEPC shall be final and binding on the Division and the foster parent. If the Regional Manager casts the deciding vote, that decision shall be final and binding on the Division and the foster parent.

Appropriate issues for the RCEPC to review include, but are not limited to the following:

(1) Differences in interpretation regarding placement and child caring issues between family case managers within the agency.

(2) Lack of use of the foster home for placement by the licensing agency.

(3) The involvement of foster parents in the choice of child(ren) placed in the foster home.

(4) Access to and availability of the family case manager.

(5) Removal of the child from the foster home, except by court order.

(6) Conflicts, difficulties, or differences between foster parent and family case manager.

(7) Implementation or interpretation of licensing practices.

(8) Involvement in the development of the case plan for the child.

(9) Failure of the agency to reassess the request for a special needs per diem for the care of a child requiring extraordinary care, as defined by the county having wardship of the child.

(10) Failure of the agency to allow a person to apply for licensure and to complete the licensing process in a timely manner.

Inappropriate issues for the RCEPC to review include, but are not limited to the following:

(1) Decisions made by the courts.

(2) Decisions made through an administrative appeal process.

(3) Licensing rules.

(4) Issuance, denial, or revocation of a foster home license.

(5) Established foster care per diem rates.

403.5 Responsibilities of the Institution and COFC During Placement

There are times when a child who is in need of out-of-home care requires placement in a facility that will provide the child with more structure and discipline than would be available in the home of a relative or a foster family home. In such cases, the child will need placement in a group home or child caring institution or hospital. The following is a summary of the different responsibilities that the institution and the placing agency have for the child during placement.

403.51 Institutional Responsibilities

The rules for group homes and child caring institutions define the responsibilities of the facility. The facility must make the following provisions for children in their care:

(1) A daily program planned to meet the physical, mental, emotional, educational, social and spiritual development and adjustment needs of the children.

(2) A treatment plan based upon the child's identified needs and the agency's case plan for the child.

(3) Quarterly written reports of the child's adjustment, and future placement planning to the placing agency and to the court reviewing the child's case, including placement status.

(4) Prompt notification to the placing agency regarding any serious problem encountered in the implementation of the treatment plan.

(5) Maintenance of the medical passport. Updates of medical passports are to be sent to the COFC quarterly.

When a child's placement is in a non-licensed facility; i.e., in an in-state facility operated by another state agency or in an out-of-state facility licensed by the state in which it is located, it is the responsibility of the COFC, as placing agency, to make arrangements with the facility to obtain

quarterly reports, including medical and educational records, regarding wards placed there.

403.52 COFC Responsibilities

The COFC, as the placing agency, is responsible for the following activities:

(1) Facilitating court reviews as necessary.

(2) Developing and updating the case plan as necessary in cooperation with the facility and the child's parent or guardian.

(3) Initiating school transfers, as described in subsection 404.331.

(4) Maintaining ongoing contacts with the institution and the child, both by visits and by correspondence with the residential director.

(5) Having face-to-face contact with the child in accordance with the risk and needs service level assessed. See Appendix F Family Case Manager Contact Standards. If the distance between the facility and the COFC is such that it precludes regular contact, arrangements must be made and formalized in writing with an appropriate agency to provide supervision. If an agency, out of legitimate need, requests the COFC in the county in which the agency's ward is placed to provide courtesy supervision, the request is to be honored.

(6) Maintaining contact with the parents or substitute parental figures to assist them in reaching the goals or decisions necessary for the child's future well-being;

(7) Encouraging and arranging parental visitation and contact while the child is in the facility.

(8) Notifying the facility of any major changes in the child's situation.

(9) Sending a quarterly updated medical passport generated from Indiana Child Welfare Information System (ICWIS) in those instances in which a Medical Passport is required. See 404.322 regarding the medical passport.

(10) Notifying Central Office of the Division of Family and Children (DFC) of child care facilities that are substandard or in which abuse or neglect of residents has occurred. If the concerns involve non-compliance with licensing standards, this information is to be directed to the Division’s Residential Licensing Unit. If there is reason to suspect abuse or neglect of any child in the facility, this information must be directed immediately to Central Office Institutional Child Protection Service Unit via the institutional reporting Hot Line at 1-800-562-2407.

404 Services for the Child in Out-of-Home Care

The county office of family and children (COFC) is responsible for providing the same mandated case management activities for children in out-of-home care as it provides for all children under its supervision. This includes responsibility for case management services and supervision which involves the following:

(1) Establishing and implementing goal-oriented case plans with measurable outcomes formulated with the child's family and utilizing input from the child's caregiver(s).

(2) Determining what services the child, the child's family, and the child's caregivers need and providing and coordinating the provision of these services based on knowledge of available community resources.

(3) Monitoring compliance with court orders and the progress of family and child.

(4) Reassessing and evaluating the needs of child, family and caregivers on an ongoing basis in conjunction with all of these individuals.

(5) Documenting the case as outlined in Section 11 of this manual.

NOTE: The Juvenile Code specifies that the foster parent and COFC shall cooperate in the development of the case plan. The COFC shall discuss with at least one (1) of the foster parents the foster parent's role regarding services to the child and family, visiting arrangements, and services required to meet the special needs of the child. The format used to implement this collaboration between COFC and foster parents is State Form 2956 Case Plan I Needs Assessment/Service for Child/Family and Case Plan II Child Information /Service Plan for Substitute Caregivers. The Case Plan II also provides health and education information to the foster parent that is a federal requirement. Refer to Section 3, Appendix A for the case plan form and instructions.

Once placement is made, the COFC assumes the following responsibilities:

Minimum Contact

The COFC must be aware of the placement status of a child at all times. The frequency of face-to-face contacts between the family case manager and the child, foster parent(s) or residential facility staff, and the legal parent(s) or guardian(s) shall be consistent with the service level established through the completion of risk and needs assessments. Contacts are to be documented in ICWIS in the contact log. There are specific circumstances that require more frequent contact, even as often as once per week. Every case opened for ongoing services, whether services referral agreement (SRA), informal adjustment (IA), or a wardship case, will have a service level based on risk and needs levels combined. Each service level has specific family contact standards; i.e., there are a minimum number of face-to-face contacts and collateral contacts the assigned family case manager is to have with the family each month. See Appendix F. Also, see subsection 1106.21 for additional information.

404.2 Visitation Policy

It is a fundamental right for children to visit with their parents. The relationship developed by the child with the parent is one of bonding, dependency, and being nurtured, all of which must be protected for the emotional well-being of the child. It is

of extreme importance for a child not to feel abandoned in placement by either the child's parents or by other siblings, and for a child to be reassured that no harm has befallen either parent or siblings when separation occurs.

Visitation for a child is an opportunity for reconnecting, and reestablishing the parent/child relationship. For the Division, visitation is to be a time for assessing that relationship. For parents, visitation is an excellent time for parents to learn and practice new concepts of parenting and to assess their own ability to parent. Visitation also serves as a motivator for the return of the child to the parents' home when parents can feel positive about their progress in applying new parenting concepts. In all cases, visitation can create an atmosphere in which the primary issues that led to the child's removal can be addressed as well as defining the degree of change that must occur prior to return of the child. As progress is made and return is imminent, visitation can ease the transition period when the child moves from a foster home to the parents' home.

Above all, visitation provides the necessary element for return of the child to the parental home. It maintains the parent-child relationship. Without this relationship, there can be no successful return home. Through careful and complete documentation of visitation in the visitation log, family case managers and foster parents can assist the court in the decision-making process regarding the child.

The term “parent”, as used throughout this delineation of policy regarding visitation, is defined as the biological parent, adoptive parent, legal guardian, or physical custodian of a child.

404.21 Frequency of Visitation

Time frames and other stipulations relative to various types of visitation are as follows:

(1) Initial Contact: Contact is to take place between the child and the legal family within 48 hours of the removal of a child from the home. Exceptions are when it is otherwise ordered by the court or the child refuses contact. When there are concerns for the child's safety, visits should be supervised. Contact can be a telephone call, contact at a court hearing, or supervised visits in the agency, a neutral setting, foster home, or parental home.

(2) Face to Face Contact: Contact is to occur within five (5) working days of the removal of the child from the parental home, unless otherwise ordered by the court or the child refuses contact. When there are concerns for the child's safety, visits are to be supervised. Face-to-face contact is to be made with both legal parents, and with siblings and any significant others. Contact is to take place in a neutral setting with supervision provided by COFC staff, if required. Otherwise, supervision may be provided by a foster parent, a service provider or another appropriate individual.

(3) Regularly Scheduled Visits: Contact is to be made on at least a weekly basis, unless otherwise ordered by the court. Initially, visits should be supervised in order for the family case manager to assess both the strengths and weaknesses of the legal parents to adequately

parent the child. As the visitation progresses, the visitation plan is to include arrangements for increased visits, overnight visitation, and extended visits to provide opportunity for family members to practice new skills and ease the transition of the child returning home.

404.22 Visitation Plan

The family case manager is to complete a visitation plan with the legal parents, foster parents, and significant others. This plan is to be generated in ICWIS and is to be completed within five (5) working days after the initial visit. See Appendix G for a copy of the format generated in ICWIS for a visitation plan. The plan shall be a written agreement detailing the time of visits, as well as the place and frequency of visits, transportation arrangements, notification of change in a visit, and who is allowed to visit, including siblings. Also, it is to include recommendations from the court, issues brought by the parent or child, and documentation. The planning of visitation is a process of careful decision-making and provides a time to inform all parties of visitation arrangements.

The following constitutes a delineation of activities and procedures involved in making a plan for visitation:

(1) Pre-planning: The family case manager must make an assessment to determine with whom the child has formed primary attachments. Primary attachments are defined as "persons whom the child loves most in all the world".

(2) Notification: The family case manager or the service provider is to be responsible for notifying all involved parties of the date, location, and time of the visit.

(3) Transportation: The COFC shall be responsible for arranging transportation of the child to regularly scheduled visits. The COFC is to be responsible for assisting parents, when parents need help, in locating transportation to regularly scheduled visits.

(4) Location: If possible, the visitation is to take place at a location that will produce the most interaction between parent and child. A more home-like setting; i.e., the parental home or foster family home, generally will provide the best environment for interaction. In choosing the location, certain factors are to be taken into consideration:

(a) Suitability for developmentally related activities; e.g., does the site allow for positive interaction conducive to the child's development.

(b) Legal parents' attitudes and feelings about the child's foster parents, and their ability to handle contact with one another.

(c) Foster parents' interest, willingness, and capacity to be involved in parent-child contacts as well as their feelings and attitudes toward the child's legal parents.

(d) Factors that might preclude visitation taking place in the legal or foster parents' homes.

(e) Consideration for the child's physical safety and emotional stability.

(5) Who Visits: Family case managers are to consider and plan visitation to include significant people in the child's life. The court order may detail who should be included in visitation. Visitation is to be supervised by agency staff or a contracted provider, if assessment indicates the child's physical safety or emotional stability would be at risk. The following persons must be considered for visitation:

(a) Legal parents. Legal parents are to be encouraged to visit together, if that is not precluded by their respective work schedules, medical or relationship/family problems. Individual visitation plans may be necessary if it is requested by the legal parents at any of the court hearings or, for divorced or separated parents, if visitation is ordered by civil divorce court.

(b) Siblings.

(c) Grandparents, if ordered by the court or if consent is given by legal parents or requested by the child.

(d) Significant others, if requested by the child and if it is determined by the COFC that visits by those persons would not place the child at risk.

(6) Court Jurisdiction: At all times, the juvenile court having jurisdiction has authority to permit or deny visitation.

(7) Alternatives: If the legal parents or the child's significant others disagree with the visitation plan and those disagreements cannot be resolved by the parties to the plan, the parent or significant others are to be notified in writing of their legal rights and options which include:

(a) seeking representation;

(b) filing a petition requesting a judicial review and modification of the visitation plan;

(c) discussing modification of the visitation plan with the family case manager's supervisor. The visitation plan is an integral part of the child's case plan and is to coincide with goals, problems, and services outlined in the case plan.

The family case manager is to document the disagreement in the contact log. During the resolution period, visitation is to continue in some form unless otherwise ordered by the court, and an interim written visitation plan is to be given to all parties.

404.23 Foster Parent Role in Visitation

The degree of foster parent involvement in visitation is to be a mutual decision reached through a consensus-building process involving the foster family, legal parents, and family case manager. The involvement varies on a continuum from minimum to maximum involvement. Foster parents' activities which support the foster child's identification and relationship with the legal family, or which acknowledge and support the legal parents' continuing role as parents can be identified as follows:

(1) Those that involve no face-to-face contact (minimum).

(2) Telephone contact or public or supervised face-to-face contact (moderate).

(3) Extensive supervised or unsupervised face-to-face contact (maximum).

If foster parents are minimally involved with legal parents during visitation, foster parents are to be encouraged to:

(1) talk with the child regarding the child's feelings about the missing parent and help the child with grief concerning separation.

(2) provide progress reports to the family case manager concerning the child.

(3) help the child to obtain gifts and cards for parents on special days.

(4) encourage parental participation in decision-making by providing information about the child to the family case manager and requesting parental opinions and feedback.

(5) prepare the child for visits and encourage the child's open expression of feelings about the visits.

(6) share the child by allowing the child to spend special days with parents as requested and when approved by the agency.

(7) refrain from demeaning the child's parents to the child or to others.

(8) respect the confidential nature of all information.

(9) allow and encourage appropriate post-placement involvement (cards, letters, sharing, or pictures).

With moderate involvement with legal parents, foster parents are to be encouraged to:

(1) allow and encourage phone calls.

(2) allow and encourage visits in the foster home with the family case manager supervising the case.

(3) discuss decisions to be made about the child with legal parents on the telephone or in person.

(4) invite parents to attend activities such as school conferences and functions, clinic appointments, etc.

(5) allow and encourage similar post-placement involvement.

With maximum involvement with legal parents, foster parents are to:

(1) allow and encourage unsupervised visits in the foster family home or provide supervision for visits.

(2) coordinate visitation arrangements as agreed in the plan.

(3) invite legal parents to participate in family gatherings and birthday parties.

(4) assist legal parents in developing parenting skills through teaching and modeling.

(5) encourage legal parents to visit with foster parents when the child is not in the home.

(6) allow and encourage a continued relationship with child and legal family during post-placement.

404.24 COFC Role in Visitation

Relative to visitation, the COFC is responsible for:

(1) talking with foster parents regarding the child's reaction to parental separation and helping foster parents to understand the child's behavior. This will assist foster parents in helping the child with grief.

(2) acting as message bearer and encouraging the child and foster parents to share information by notifying foster parents of special days and keeping foster parents informed of the visitation plan.

(3) being available to foster parents to provide knowledge about legal parents.

(4) keeping foster parents informed of progress in preparing the child and legal parents for changing situations and advising the foster parents of possible reactions on the part of the child and legal family concerning those changes.

(5) being supportive of the foster parents' involvement with legal parents and being available to interpret and mediate when appropriate.

(6) clarifying roles with the foster parents and supporting foster parents in the role agreed upon.

(7) listening carefully to and considering the point of view of the foster parents.

404.25 Restricted Visits/Special Conditions/Termination of Parental Rights

Once the visitation plan has been developed, certain issues may arise which require further clarification:

(1) Restricted Visits: The visitation plan shall not be violated unless:

(a) the child is placed in a situation which would seriously impair or endanger the child's emotional or physical health. Should this arise, a discussion between all parties involved in the visitation plan should be held with the immediate goal being to resolve the problem and protect the child. Issues and results of these discussions are to be recorded in the visitation log.

(b) the court having jurisdiction orders a visitation plan different from the one established. In this case, the court order shall take precedence.

(2) Special Conditions: Conditions could arise which would make the visitation plan temporarily invalid. Examples of such circumstances include a parent or child who is in an accident, in the hospital, arrested, admitted to a psychiatric hospital, suffering illness; hampered by inclement weather which closes school, offices, or roads. If such a condition arises, it is to be explained to the child immediately; and a temporary alternative schedule is to be initiated or an alternative site selected. When visitations take place in another location, this change needs to be entered into ICWIS on the visitation plan screen by modifying the schedule for the visitation plan (change location). If visitations are canceled or rescheduled, this is to be recorded in the visitation log. A new written visitation plan is to be created anytime there is a change in the plan and distributed to all parties.

(3) Termination of Parental Rights: If, during the course of the child's placement, it has been decided that reunification is not possible; and a decision to file for termination of parental rights is made, visitation shall continue as planned unless:

(a) a court order prohibits visitation;

(b) parents reply in writing that they no longer wish to visit; or

(c) the child is placed in a situation that seriously impairs or endangers the child's emotional or physical health, at which time a court order shall be sought to cease visitation on these grounds.

404.26 Disrupted Visitation

Disruption, as it relates to visitation, can be defined as a situation in which modification of the visitation plan is indicated because all parties do not agree with the current plan. The visitation plan can be disrupted by any of the participants involved. Once the plan is agreed upon and visitation has begun, should a disruption occur, the family case manager shall be responsible for contacting all parties involved in the visitation plan and for establishing a meeting time to discuss the problem. Prior to this meeting the family case manager should consider reassessing risks and needs of the child and family, if there have been changes in the case that may be causing the disruption. The family case manager shall discuss with parents and foster parents the long- and short-term goals of the agency for the child, and the assessments will help all parties to focus on what needs to be accomplished. Disruptions to a plan are recorded in the Disruption screen opened from the visitation plan screen.

Modifications can be made at this time, if all parties are in agreement. If a decision is not reached which is agreeable to all parties, the family case manager is to:

(1) refer parents to legal counsel or for counseling.

(2) discuss the situation with the child and possibly refer the child to counseling to address fears or concerns the child may have about visitation.

(3) refer the matter to the court for a specific order or for modification of the existing order regarding visitation.

404.3 Minimum Provisions

The COFC shall provide, in a timely manner, the following for each child in out-of-home care:

404.31 Clothing

The COFC is responsible for providing the child with clothing. The method may vary from county to county. The COFC Director, through written local guidelines, must ensure that COFC staff and foster parents have a clear understanding of clothing provisions. Foster parents are to be provided a written copy of this guideline.

Regardless of the system used to purchase clothing for a foster child, the COFC is to provide to the foster parent a minimum clothing list. This will assist the foster parent to provide the minimum clothing required at all times. The minimum clothing shall be available to the child if the child is transferred from one foster home to another.

404.32 Medical and Dental Care

Licensing rules prohibit placing a child having a communicable or contagious disease if there are other children in the home unless plans are based on competent medical advice. Therefore, the COFC is to make arrangements for a medical examination of the child prior to placement or immediately following an emergency placement. The COFC is responsible for providing ongoing medical and dental care for all children in placement, or for seeing that the care is secured by the home or facility.

Licensing rules also require that the health of the foster parents "be such that it will not be detrimental to the health and welfare of the children." If a communicable disease is contracted, the foster child "shall not be permitted to remain there unless suitable health precautions are taken."

404.321 HIV/AIDS Policy for Foster Care

Please refer to Appendix H for general information regarding HIV/AIDS and for an updated "Preamble and Rationale for HIV Policy for Foster Care", which policy appears below. The information in the preamble is an updated version of the product of a task force initiated by the Indiana State Department of Health to address concerns of agencies providing services to children with HIV/AIDS and is directed to those agencies in general.

TESTING

Policy (Testing): HIV is a life-threatening blood-borne pathogen that requires continued vigilance in terms of controlling transmission. Testing for HIV infection is to be considered for children who have signs or symptoms of HIV infection confirmed by a physician, or who are at high-risk of HIV infection. Children in the following categories are considered high-risk:

(1) Children with a parent who is documented as, or who admits to being HIV-infected, or regarding whom there is other credible evidence, such as family case manager knowledge of past history, to indicate that the children may be high-risk.

(2) Children with a parent who is an intravenous drug user.

(3) Children with a parent who is sexually active with bisexual or drug-using partners, or who uses prostitutes.

(4) Children with a parent who is a prostitute or who has a history of multiple, casual sexual partners.

(5) Children with hemophilia or other bleeding disorders or who have received blood products prior to March 1985. NOTE: Hemophiliacs and others receiving blood products after 1985 are not to be considered at high-risk on that basis.

(6) Children from countries with a high rate of heterosexual transmission of HIV, such as parts of Africa, Haiti, and other Caribbean countries.

(7) Children with histories of high-risk behavior, including intravenous drug use and prostitution.

(8) Children who have had oral, anal, or vaginal penetration by a high-risk person.

(9) Children who have had oral, anal, or vaginal penetration by an unknown person or a person whose HIV status is unknown.

Procedure (Testing):

Determination of need for testing:

If a child has signs or symptoms that may be consistent with HIV infection, the child is to be evaluated by a physician to determine if testing is necessary and appropriate.

Testing is recommended for children at high-risk of HIV infection; e.g., having a parent with AIDS, even if the child is asymptomatic. For infants under the age of 18 months, viral load testing is to be done at one (1) month, two (2) months and six (6) months of age or greater. See subsection 404.3211 under "Tests for HIV Infection". Three (3) negative tests indicate an HIV negative status. Children who are 18 months of age or older are to be tested for positive blood antibodies.

While it appears that there is not a strong correlation between sexual abuse of children and HIV infection, testing is to be considered for children who have been molested if it is likely they have had oral, vaginal, or anal penetration by a high-risk or unknown person.

Children with a documented exposure are to be tested at the time that the incident is reported to determine baseline status and again after three (3) and six (6) months to determine if seroconversion (infection) has occurred. Children who are HIV seropositive at the time of initial testing are unlikely to have been infected from the episode in question, unless there is a delay of greater than two (2) weeks between the event and the testing. If a child tests negatively six (6) months after the

exposure, the child may be considered uninfected from the reported incident.

It is important to realize that if repeated molestations or other high-risk events; e.g., intravenous drug use, occur during the six-month period, it is necessary to continue testing the child until six months from the last possible exposure.

If a child is asymptomatic and is judged not at risk for HIV infection, testing is not necessary or recommended. However, the child and/or the child's parent, guardian, or custodian is to be advised of the indications and availability of HIV testing.

Informed consent for testing:

State law requires obtaining informed consent prior to HIV testing (IC 16-41-6). See Appendix I. If testing is deemed appropriate and the child is not in the legal custody of the agency, voluntary informed consent must be obtained from the child's parent, guardian, or custodian. The informed consent is to include:

(1) the purpose and meaning of HIV testing;

(2) the interpretation of test results;

(3) basic information about HIV infection;

(4) the legal consequences of having a HIV seropositive status, including mandatory reporting and the duty to inform sexual and needle-sharing partners; and

(5) possible psychosocial consequences to the child and/or family if the child is HIV-infected.

If consent is not given, permission to test may be sought from the court on the following bases:

(1) There is a physician-certified medical emergency or need for continued post-emergency medical care requiring knowledge of HIV status for diagnostic or treatment purposes (IC 31-32-12). NOTE: This would not require obtaining a CHINS petition.

(2) Filing a CHINS petition based upon medical neglect is appropriate under IC 31-34-1-1.

(3) A parent, guardian, or custodian refuses medical treatment for a child on religious grounds, and it is believed that the child's health requires knowledge of HIV status for medical treatment. IC 31-34-1-14

permits the court to order medical treatment for a child, if the child's health requires it, despite the objections of the parent, guardian, or custodian on religious grounds.

If the child is in the legal custody of the agency, court approval is to be sought for HIV testing if the child's situation meets the high-risk criteria of this policy. The child may have been adjudicated a CHINS, and the court may have authorized the provision of routine medical care as part of a standing order. However, the matter of obtaining HIV antibody tests is to be discussed with the court prior to obtaining any such test in order to determine how the court wishes to proceed in such cases.

Financial considerations (Testing):

Responsibility for expenses of HIV antibody testing, initial or subsequent, will fall to the parent, guardian, or custodian first and then ultimately to the COFC legally responsible for the child's care.

If the child is eligible for and on Medicaid, Medicaid will pay for testing as long as there is a medical need to test. This includes testing for children who are symptomatic and for the children who are asymptomatic but at high-risk for AIDS. Testing does not require pre-authorization.

The Indiana State Department of Health operates free Counseling and Testing Sites (CTS) throughout the state. Persons age 13 or greater may be counseled and tested at these sites without charge. Children under the age of 13 may have special needs and require counseling beyond the capability of staff at these sites. The CTS offer both anonymous (without name or identifiers) and confidential (with name and identifiers) testing. Clients must understand the difference between anonymous and confidential testing as legal or other considerations may exclude use of anonymous testing.

If a child meets the criteria for the diagnosis of AIDS, the child may be eligible for benefits such as Supplemental Security Income and/or Medicaid. If the child is eligible for and on Medicaid, Medicaid will pay for the normal range of services that are medically necessary. Standard Medicaid requirements regarding pre-authorization for payment apply to AIDS cases.

Psychosocial consideration (Testing):

If a child is found to be HIV-infected, the parent, guardian, or custodian may find this information very stressful. Because of the association of HIV infection with stigmatized populations, some people may fear "guilt by association" and believe that social reprisal, including destruction of personal property or reputation, loss of employment or educational status, will result

if the child's HIV status becomes publicly known. Since HIV infection is a stigmatized disease, HIV-infected children, their parents, guardians, or custodians may avoid the usual resources of friends and extended family.

Families of children with HIV infection require education concerning appropriate infection control practices, although in most situations, the need for such precautions is minimal. See Universal Precautions below.

Many persons believe that HIV infection is synonymous with AIDS or implies impending death. Even if reassured that the child may have relatively good health for a period of years, caregivers will have many questions and concerns about their ability to deal with a stigmatizing, chronic, and ultimately fatal disease. Many issues, including the child's immediate and future medical care, financial concerns, and the family's well-being will be raised and need to be addressed. These needs go beyond the usual post-test counseling, and resources must be developed to address these needs. While the agency may contract with private or public agencies to provide counseling for families with HIV-infected children, it is recommended that appropriate agency staff be aware of the content of post-test counseling for HIV-infected persons. It is also recommended that all counselors used by the agency be trained according to the Centers for Disease Control's pre- and post-test counseling for HIV antibody testing. Simple and clearly written pamphlets containing necessary information and referrals are to be made available to ease family concerns and facilitate appropriate follow-up care for the child.

CONFIDENTIALITY

Policy (Confidentiality): Confidentiality of positive HIV status is protected by law in IC 16-41-8. See Appendix I.

Persons with HIV infection are vulnerable to discrimination. This may be due to the public's association of HIV infection with stigmatized populations such as homosexuals and intravenous drug users. In addition, despite scientific evidence that HIV is spread by limited means and is difficult to acquire, the public remains fearful of contagion. Consequently, the issue of confidentiality is extremely important to the overall physical and emotional well-being of the infected child.

The policy of the Division is to share information concerning a child's HIV infection with the child and with specific persons who clearly require knowledge because of their relationship with the child; e.g., the parent. It is believed that clear and accurate information about HIV infection, a child's health status, and appropriate infection control measures must be given to parents, foster parents, guardians, or custodians to enable them to make an informed decision about their ability

and willingness to provide care to the child. If caregivers make such an informed decision, the possibility of having to move the child from the placement is decreased; and the caregiver is in a position to act in the best interests of the child.

It is acknowledged that caregiver education and training may be required before the caregiver feels capable of providing care for an HIV-infected child. The Division will provide or arrange for such training on a regular basis or as needed.

Procedure (Confidentiality):

The following persons are to be informed regarding a child's positive HIV status:

(1) Specified agency personnel

If a court order is in effect assigning responsibility for a child to an agency, HIV viral load (see Appendix H) or antibody test results shall be returned to the administrator or the administrator's designee in a sealed enveloped marked CONFIDENTIAL. If a COFC is the agency responsible for a child who is tested for HIV infection, the person designated to receive the test results is the COFC Director. The person receiving information may share it with appropriate staff on a

need-to-know basis. All DFC staff having information regarding a child's HIV status must maintain that information as confidential.

(2) The court

If there is a court order in effect regarding the child, the court, being ultimately responsible for the child, must be advised of the child's positive HIV status by the agency legally responsible for the child. A policy for conveying this information to the court that preserves strict confidentiality is to be developed which meets court-specific requirements. Those developed by COFCs will need to be in accord with Central Office policy also.

(3) The child

The child is to be advised of the HIV status in an age-appropriate fashion by the agency legally responsible for the child in accordance with expert advise and with assistance from appropriate professionals from other disciplines as necessary.

(4) The child's biological parents or legal guardian

Biological parents and legal guardians are to be advised unless their rights pertaining to the child have been terminated. It is recommended that the parent or guardian be informed in a meeting with a trained counselor or health care professional and the child's family case manager. A knowledgeable physician or health care professional is to be available on a referral basis for more technical or medical information. The notification of parent or guardian is to be documented in writing with copies of the medical determination of the positive HIV status available. Available services for the child and family can be discussed at this meeting. Follow-up meetings are to be planned as needed.

(5) Child's prospective adoptive parent

The fact that a child is HIV seropositive is not to be directly stated in any adoption exchange information but is to be referred to as a medical problem and shared with prospective adoptive families. Prospective adoptive parents are to be informed if a child has not been tested for HIV infection but is at high-risk for the disease. Initially, this information is to be conveyed orally. If interest in adopting the child remains intact, written information concerning the child's HIV status may be provided to the adopting parents with the provision that, if the child is not adopted, the written information regarding the child's HIV status is to be returned to the family case manager.

(6) Specified providers of substitute care

Persons acting in loco parentis are to be advised of the child's HIV positive status. Every residential institution or group home should have clear policies and guidelines determining "need-to-know" and the management of information pertaining to HIV status. In the interest of confidentiality, other types of facilities, such as child care centers and schools, are not to be notified by the agency of a child's HIV positive status.

Any written communication emanating from the agency concerning the HIV status of a child must be marked CONFIDENTIAL on each sheet and on the mailing envelope with copies maintained in a locked file.

Because of the existence of a documented lack of transmission of HIV within a family or home setting, it is inappropriate, and may be considered a breach of confidentiality, for staff to reveal a child's HIV status to other foster children, children in group homes or other institutions, or to the natural parents of these other minor residents.

UNIVERSAL PRECAUTIONS

Policy (Universal Precautions): State law, in IC 16-41-11 and 410 IAC 1 in the Indiana Administrative Code mandates the use of Universal Precautions. See Appendix I. Universal precautions consist of the use of appropriate barrier precautions (gloves, for example) by workers with occupational exposure to blood to prevent contact with blood or other body fluids capable of transmitting HIV infection. Since HIV status is rarely known, all persons should be potentially considered HIV-infected; and precautions are to be taken whenever blood or other specified body fluids are handled. Since all persons are considered potentially HIV-infected, there is no need to identify those who are known to have HIV infection, as appropriate measures will be taken in all cases.

Procedures (Universal Precautions):

All personnel whose occupation makes contact with blood or other infectious fluids probable will be educated in the appropriate use of universal precautions in accordance with Indiana law. In addition, designated agency staff will be able to provide or arrange for the provision of information and education about universal precautions as appropriate to HIV-infected children, their parents, guardians, or custodians, and to foster parents willing to provide care for HIV-infected children.

NOTE: In the family, school, or home setting, the primary risk of HIV transmission occurs from exposure to blood. Body fluids such as tears, saliva, urine, feces, vomitus and nasal secretions, if not visibly contaminated with blood, are not infectious; and gloves or other barrier precautions are not necessary for routine child care, including diapering/toileting, feeding, or burping. These same body fluids, if visibly contaminated with blood, should be considered potentially infectious; and universal precautions should be utilized.

If any child has diarrhea or an acute, communicable disease, it is prudent to use barrier precautions when handling that child's body fluids, regardless of HIV status, in order to prevent acquiring or transmitting these infections to others in the home, school, or institution. It is important to note that whether or not barrier precautions are used in any given situation, thorough hand washing is essential after handling any body fluid in order to avoid spreading other sources of infection contained in the fluids.

SCHOOL ATTENDANCE:

Policy (School Attendance): HIV-infected children are to lead lives that are as normal as possible. Every effort is to be made

to ensure that they develop and maintain age-appropriate social relationships and receive a formal education. In general, there is no health reason for denying most HIV-infected children admittance into most schools or child care programs. However, a more restricted environment is advisable for some children such as:

(1) the infected preschool-age child, particularly the child who is at the stage when everything goes into the mouth;

(2) some handicapped children who lack control of their body secretions or who display aggressive behavior; and

(3) those children who have oozing or bleeding lesions that cannot be covered.

In some instances, such as the occurrence of an outbreak of chicken pox or measles, it may be necessary to keep the HIV-infected child at home for the child's well-being.

NOTE: Relative to school attendance, parents, guardians, or custodians of HIV-infected children under the care and supervision of the Division are to discuss their child's immunization and health status with a knowledgeable physician, preferably the primary health care provider for the child. In the event that a school refuses admittance to an HIV-infected child, state law provides the child with recourse to the ruling of the local health officer whose decision can be appealed to the State Health Commissioner.

Procedure (School Attendance): HIV-infected children may attend child care, nursery, grade, high, or other schools.

The Indiana State Department of Health, in its guidelines for school attendance of children with HIV infection, makes the following recommendations:

(1) No child, regardless of HIV status, is to attend regular school if the child lacks control of bodily functions, exhibits biting behavior, or has open sores that cannot be covered.

(2) No child, regardless of HIV status, should attend regular school if the child has acute febrile, upper respiratory, or diarrheal illnesses.

(3) Someone within the school setting; e.g., the school nurse, should be responsible for advising the local health officer or private physicians of outbreaks of communicable diseases in the school.

If a school denies attendance of a child on the basis of HIV alone, the family is to contact the Indiana State Department of Health (1-800-433-0746).

404.322 Medical Passport Program

In response to P.L. 344-1989 passed by the Indiana General Assembly, the Central Office of the Division of Family and Children (DFC) developed procedures and related forms for implementing a medical passport program. These procedures and forms were updated in 1998 due to the development of the booklet entitled "Medical Passport" (DFC PAM 036 (4-98) 3631), commonly referred to as the "Blue Book"; and the electronic Indiana Child Welfare Information System (ICWIS). The combination of the Blue Book and appropriate screens in ICWIS constitutes a system for obtaining and maintaining the medical care records of Indiana wards in foster care, including some in child care institutions. Specifics related to the legislation are as follows:

Target Population

The law requiring a medical passport program applies to all children who receive foster care that is funded by the DFC or the COFC, including Indiana children in out-of-state placements. The term "foster care", as used in the law and in this subsection, means care provided in a foster home. Indiana statute mandates maintenance of a medical passport for children in foster care only. However, once a medical passport has been established for a foster child, the policy of the DFC requires maintenance of the medical passport for that child, if:

(1) the child is placed in any other type of residential care setting directly from a foster home; and

(2) a CHINS status is maintained on an uninterrupted basis.

Legal Base

The authority for developing these procedures/forms comes from three chapters of the Indiana Code, IC 12-17-9, IC 12-17-10 and IC 12-17-11, all of which were effective 7/1/89.

404.3221 Definition of Medical Passport

IC 12-17-11 requires the COFC placing a child in foster care to issue a medical passport booklet for the child to the child's foster parents at the time of placement. In 1998, the Medical Passport or "Blue Book" was established for use as a means for foster parents to maintain a written record of a

foster child's medical and dental care while in out-of-home placement. ICWIS also has a section for the family case manager to maintain an electronic record of the child's medical information. See Appendix J for a copy of the Blue Book and for the Medical Passport as generated via ICWIS. See the following subsections under this topic for procedures concerning gathering and exchanging medical passport information prior to or at placement of a child in foster care, at the conclusion of the foster care placement and in inter-county/state placements.

Two other forms that are to be given to the foster parent are:

(1) SF 45093/FPP 3319 Authorization for Medical Care (see Appendix G in Section 11 of this manual); and

(2) a copy of a consent form for release of mental health information if a child is to be seen by a mental health provider. A sample copy of such a form appears in Appendix K of this section.

The passport must remain with the child until the child returns home, is adopted, or is placed according to another permanent plan, at which time the passport shall be returned to the placing county that issued the passport.

404.3222 Medical Passport Procedures Prior to or at Foster Care Placement

Prior to or when a child is placed in foster care, the family case manager is to speak to the parent, guardian, or custodian about all topics in the Blue Book and record the results. For purposes of the Blue Book, "provider" means a physician, dentist, registered nurse, licensed practical nurse, optometrist, chiropractor, physical therapist, psychologist, audiologist, speech-language pathologist, home health agency, hospital, or nursing home facility. The family case manager is to determine if the child is on Medicaid or is eligible to receive Medicaid benefits. The information obtained from the parent(s) is to be

entered into ICWIS in the appropriate fields, and the Blue Book is to be given to the foster parents. The family case manager is to discuss an arrangement for exchanging information from the Blue Book to ICWIS and vice versa with the foster parents. This exchange is to occur at least on a quarterly basis, preferably during a collateral visit; and an electronic medical passport is to be sent to the foster parent to be sure the same records are being maintained by COFC and foster parent. Foster parents are to be advised that they may sign for routine medical treatment but that the COFC must be contacted as soon as possible if the treatment is anything other than routine care. They also need to be aware that the COFC must sign a consent form for mental health treatment prior to the child being taken to a mental health provider. (IC 16-36-1.5)

(1) When the Child Has a Previous Provider

If ongoing care has been provided to a child and the previous provider is a physician, the COFC is to request the provider to assist in verifying information about the child in the Blue Book. If the physician has not seen the child recently (within the past six (6) months), the physician may want to examine the child in order to recommend future health care needs. The family case manager or foster parent is to arrange an appointment for this examination as soon as possible. If possible and appropriate, the parent of the child is to attend any initial examination.

Request the provider to complete the section on Physical Examinations in the Blue Book (DFC PAM 036 (4-98) #3631) as a part of the examination. If the provider identifies a medical problem, request the provider to complete the Blue Book section on Identified Medical Problems (problem identified, date identified, date resolved, and signature). The foster parent or the family case manager can complete the provider's address and telephone number.

(2) When the Child Has No Previous Provider

When a child comes into care and has not been seen by a doctor, or if the family case

manager cannot ascertain whether the child has been seen by a doctor recently, the child is to be taken to see a provider used by the COFC. The child is to be given a physical examination appropriate for the child's age. The provider is to be requested to complete the periodicity schedule and information concerning identified medical problems in the Blue Book according to the instructions in (1) above.

404.3223 Medical Passport Procedures During Foster Care Placement

When a foster child requires medical treatment, the foster parent is to arrange an appointment with a Medicaid provider who is approved by the COFC. At the time of treatment, the foster parent can use the SF 45093 / FPP 3319 Authorization for Medical Care provided by the COFC to authorize provision of routine and emergency medical treatment as required by the provider. The foster parent is to provide the Blue Book and request the provider to complete the line on the Identified Medical Problems page in accordance with instructions in subsection 404.3212 (1).

If the child is eligible for Medicaid, the physician is to send a claim form to Blue Cross/Blue Shield for reimbursement from the Medicaid program. If the child is not eligible, the provider is to bill the COFC in the manner agreed to by both agencies.

404.3224 Medical Passport Procedures at Exit from Foster Care

When a permanent placement (return to the biological parents, adoption, or other permanent plan) has occurred, the family case manager is to review the child's Blue Book with the foster parent(s) to determine if there is a current recommendation for the future health care needs of the child. If the child has not been examined by a physician within the last 12 months or has a chronic condition, the child is to be examined again to obtain a current recommendation from the provider regarding the child's ongoing health care needs. Post-examination procedures for obtaining recommendations for the child's future health care needs and for billing by the provider are identical to those contained in the previous portions of this subsection.

At the time the child is transferred from foster care to a permanent placement, the family case manager is to obtain the Blue Book from the foster parent. An electronic medical passport is to be provided to the child's permanent caregiver by the COFC. Care must be taken to preserve confidential identifying information, if the permanent caregiver is an adoptive parent.

404.3225 Medical Passport Procedures in Inter-county/State Placements

If a child is placed in foster care out-of-county/state, the COFC placing the child is responsible for the following:

(1) Issuing the child's Blue Book and other forms necessary to procure medical care for the child to:

(a) the appropriate governmental entity in the county/state in which the child resides in foster care that is responsible for the child; or

(b) directly to the child's foster parents by agreement with the appropriate governmental entity in the county/state in which the child resides.

(2) Advising the child's foster parents of the procedure for billing the child's medical services to Medicaid or to the COFC and establishing a procedure for updating the electronic medical passport.

(3) Collecting the Blue Book and any other completed medical records when the child is returned to the biological parents, adopted, or placed according to another permanent plan.

All other maintenance responsibility for the Blue Book rests with caregiver. The appropriate governmental entity in the county/state in which the child resides or the child's caregiver is to be advised of the requirement to consult with the placing agency prior to provision of anything but routine medical care as defined by the child's condition.

Regarding any placement of a child in foster care in another state, it is not possible to enforce the Indiana requirement for medical passport maintenance. However, cooperation in this regard is to be sought from the caregiver.

404.33 Educational Needs

The COFC is responsible for the educational needs of the child in care. The child is to attend only accredited public schools unless the parents approve or request that the child continue or be placed in a private school and are willing and able to pay for all related costs. County expenditures for education in private schools are not allowable. Subsection 404.332 deals with the special educational needs of children in care.

404.331 School and Tuition Transfers and Reporting Requirements

In 1996, the Juvenile Code was modified to require the court to make findings regarding the "legal settlement" of all children placed in residential or foster care. This information is required in order to determine responsibility for payment of education costs. (IC 31-34-20-5 and IC 31-34-21-10)

If the child is placed in a school within the school corporation where the child has legal residence, no transfer tuition is required, of course. However, if the child is placed in a school corporation within the county or out-of-county/state that is different from the school corporation where the child has legal settlement, the school corporation where the child has legal settlement is required to pay transfer tuition. No later than 10 days after a county initially places or changes the placement of a child, the county that placed the child is required to notify:

(1) the school corporation where the child has legal settlement; and

(2) the school corporation where the child will be attending school

regarding the placement or change of placement.

Before June 30 of each year, a county that places a child in a home or facility shall notify the school corporation where the child has legal settlement and the school corporation in which a child will attend school whether the child's placement will continue for the ensuing year. Absent the existence of any plan to move a child at the time the above-noted report is due, the child would be reported as remaining in placement for the next year.

The notifications and reports outlined above are to be made by the county office of family and children if that office placed or

consented to the placement of the child. Otherwise, the court or other agency

making the placement would make these reports/notifications. (IC 20-8.1-6.1-5.5)

404.332 Special Education and the Surrogate Parent Program

Federal law in 20 USC 1401 et seq. (1976), and Indiana law in IC 20-1-6, implemented by Article 7, formerly known as Rule S-5, provides for special education programs and related services without charge by the public schools of Indiana. This includes the Indiana School for the Deaf, the Indiana School for the Blind, Silvercrest Children's Development Center; Northern Indiana, Evansville Psychiatric Children's Center, Muscatatuk and Fort Wayne State Developmental Centers; Madison, Logansport and Richmond State Hospitals; and LaRue D. Carter Memorial Hospital.

In effect, Article 7 guarantees that children with disabilities between the ages of 3 and 21 will be provided a free and appropriate public education through the development and implementation of an individualized education program (IEP) designed to meet the assessed educational needs of each student. It assures that testing and evaluation materials, procedures, and interpretation of results are not biased, and that each student with disabilities will be educated within the least restrictive environment appropriate to meet the student's needs.

All procedural safeguards of due process are provided to protect the rights of children, parents, and surrogate parents. The child, parent, teacher, school administrator, or the child's family case manager may initiate a referral of the child for an educational evaluation. For children with disabilities whose parents are unknown or unavailable or who are wards of county offices of family and children and reside in foster homes, group homes, child care institutions or nursing homes, an educational surrogate parent must be assigned at the time of referral. The administrator of the special education program that the child attends is responsible for assigning the surrogate parent. A surrogate parent may be a parent, foster parent or volunteer, over the age of 18, who has been trained to assume the responsibility of representing the eligible child in the special education decision-making process.

Because of the potential for conflict of interest, employees of the state or local agencies responsible for the care and education of a child; i.e., any employee of Central Office or a COFC may not serve as that child's surrogate parent. However, the COFC has an obligation to notify the director of special education of any child under the care and supervision of the COFC who may require special education assistance so that the student's IEP can be implemented in a timely manner.

The foster parent may be the surrogate parent, if they have received training and are assigned to the child by the special education director of the local school corporation.

The rights of a surrogate parent are to:

(1) have a free, appropriate public education for their child;

(2) inspect and have a copy of all records with regard to their child's educational program;

(3) request changes, if inaccurate or inappropriate information is contained in their child's records;

(4) have an appropriate and nondiscriminatory educational assessment for the child in the child's primary language;

(5) be fully informed about evaluation procedures, tests, and all results;

(6) seek an independent evaluation of the child, if the surrogate parent thinks the school's evaluation methods or results were inappropriate;

(7) participate fully in planning the child's individualized education program (I.E.P.);

(8) know about special education services available to the child;

(9) have the child educated in the most normal setting possible;

(10) question the appropriateness of the child's educational program;

(11) decide if a proposed special education placement is appropriate for the child by signing, or refusing to sign, for placement;

(12) talk with people involved in the child's education and to receive regular progress reports and other communications routinely given to parents;

(13) give informed consent before any major change is made in the child's education program;

(14) call for a parent/school conference, new evaluation, or planning meeting whenever necessary;

(15) be accompanied by another person during any school meeting;

(16) be notified in writing when the child is being tested, a change in placement is being discussed, a change in the educational plan is being considered, or a case conference or educational planning meeting is being called;

(17) be informed of, and initiate due process procedures; and

(18) participate as a partner with the school in planning the child's individualized educational program.

The responsibilities of a surrogate parent are:

(1) learning about the child's educational needs by observing the child at school, talking with the child, reviewing the child's records, looking at the child's school work, and talking with teachers, therapists, family case managers, counselors, etc.,

(2) participating in school meetings and sharing information that has been gathered;

(3) monitoring the child's educational development during the school year and participating in a review of the program at least once a year;

(4) serving as the child's advocate by requesting appropriate services or making complaints about services or the lack thereof, if necessary;

(5) negotiating with the school, if there is any disagreement about the child's special needs or education program;

(6) representing the child in any complaint or due process procedures;

(7) using discretion in sharing information about the child with personnel from the school and care facility and complying with laws concerning confidentiality; and

(8) facilitating interaction between the school and other agencies that work with the child; such as the COFC, nursing home, or state hospital.

Family case managers may assist surrogate parents by contributing information about their understanding of the child's educational needs. The family case manager may also attend case conferences and annual case reviews.

IC 20-1-6-19 is the state statute that provides for the placement of severely handicapped children in private in-state or out-of-state schools. A child considered under this statute must have

severe physical, intellectual, sensory, or social-behavioral deficits which prohibit the child's ability to function in and benefit from special programming in the local school corporation. The COFC may contact the local school corporation and request that a child be referred for an evaluation to alert the school regarding a child who is possibly in need of a special educational placement setting, since the local school corporation must initiate the application for consideration under Article 7. A surrogate parent must be assigned by the local school corporation at the time of referral, if this has not already been done.

A case conference procedure is to be utilized to determine if a local school corporation has exhausted all local options for providing the related services and special education the child needs. If it is determined that the child's educational needs cannot be met locally, the local school corporation can make application for private special school attendance (Article 7). A special review committee appointed by the Department of Education (DE), Division of Special Education, reviews the application and determines if the child is eligible for placement in a state-operated facility or private special school. Each placement is reevaluated at the end of the school year to determine if the child is eligible for continued placement or if the local school corporation could provide the needed program.

If a child is eligible for placement in a private in-state or out-of-state special setting, the state is to pay the costs of the services that exceed the regular cost of educating children of the same age and grade level in the child's school corporation. The local school corporation is to pay the share of the total tuition cost that is the regular per capita cost of general education in that school corporation. IC 20-1-6-18.2 places limitations on transportation for individualized education programs and residency in public or private facilities of a more restrictive educational setting than the local school corporation could provide. This cite also designates financial responsibility for transportation in a variety of circumstances. (Refer to section 403.114 regarding placement in State Institutions.)

404.34 Discipline Policy

Discipline is training that develops self-control, character, orderliness, and efficiency. Through the application of effective discipline, the foster parent will teach the child responsible behavior; and the child will learn behaviors that will assist the child to develop into a responsible adult. Discipline is an ongoing process of teaching children responsible behavior through example as well as through various other activities and techniques. It helps to enable a child to develop a conscience, which is necessary to become a responsible, self-directing individual. Punishment differs from discipline in that punishment controls a child's behavior through the use of force or authority and deals more with a child's present or past behavior than with future behavior.

The most important factor regarding discipline is the child/caregiver relationship. Ongoing communication between the child and the foster parent provides both with information as to how their behavior affects the way others see and relate to them. Since foster parents have not had the benefit of having a long-term relationship with a foster child, the trust and bond that foster parents probably have with their own children is not necessarily present with a foster child. Therefore, techniques that might be very effective with one's own children might be ineffective or lead to mistrust between foster child and foster parent. Many children who have been severely physically abused will not react to a "typical" spanking, while others may be traumatized due to their memories of their past experiences. In addition, it has been found that the parents of many of the children who have been physically abused were abused themselves as children. Implementing different types of discipline other than physical punishment helps stop the generational cycle of abuse.

Discipline involves teaching children that their behavior results in certain consequences. An awareness of this will help children to control their own behavior. There are three (3) types of consequences: natural, logical, and artificial (Ryan, 1988).

Natural consequences are those that happen without any intervention by a foster parent. For example, if the child stays up too late at night, the child will be tired the next day.

Logical consequences are those that are put into effect by the foster parent when the behavior and consequences are directly related. For example, if the child stretches a curfew to come home, the curfew will be set for an earlier time.

Artificial consequences are those that are put into effect by the foster parent, but there is no clear relationship between the behavior and the consequences. For example, if the child stays out later than the curfew, the child is not allowed to watch television the next day.

These three types of consequences can be seen as a continuum with natural being the most effective and artificial being the least effective. All have some effect depending upon the situation and how the foster parent interprets the situation to the child.

Corporal punishment, which includes physical hitting or any type of physical punishment inflicted in any manner upon the body is not to be used on children in foster care. The following punishments are prohibited also:

(1) Physical exercises such as running laps or performing push-ups shall not be used.

(2) Requiring or using force to acquire the child t take an uncomfortable position such as squatting, bending, or repeated physical movements shall not be used.

(3) Children shall not be:

(a) subjected to verbal remarks that belittle or ridicule them or their families.

(b) denied emotional response as punishment.

(c) denied essential program services as punishment.

(d) denied meals, clothing, bedding, sleep, mail, or visits with their families as punishment.

(e) threatened with loss of their placement as punishment.

(f) bodily shaken.

(g) placed in a locked room.

(h) held with mechanical or chemical restraints.

These prohibited forms of discipline are listed in ICWIS. Allegations regarding foster parents' use of corporal punishment on foster children are to be entered into the intake module of ICWIS. If legal sufficiency is not met, the complaint is to be investigated by the licensing unit as an infraction of the licensing agreement or noncompliance with the case plan; and appropriate action is to be taken in accordance with Section 6 of this manual. If legal sufficiency is met, the complaint is to be investigated immediately following the requirements of any other abuse or neglect complaint. In either case, the intake is to be linked to the child's case; and the foster home worker is to be notified. Questions or concerns regarding the discipline policy should be discussed with the foster family home worker during the home study process. At any time following placement, both the foster family home case manager and the child's family case manager need to be available and accessible to the foster family to discuss concerns related to a specific child.

404.341 Techniques

Throughout the teaching/learning process of helping the child develop into a responsible adult, the foster parent is to employ four (4) basic principles as follows:

(1) Identifying positive behavior

(2) Rewarding positive behavior

(3) Identifying unacceptable behavior

(4) Learning to deal with unacceptable behavior

There are several methods for encouraging internal control and responsibilities in children including contracts, behavior management, and corrective action.

404.3411 Contracts

Contracts are statements, either verbal or written, by which the foster parents and the children negotiate a mutually acceptable agreement. Contracts can be a simple and convenient method of helping children to acquire self-discipline because contracts:

(1) involve the children in making their own decisions and taking responsibility for their own actions.

(2) are flexible and can be negotiated to meet the requirements of the situation.

(3) are individual and can be tailored to meet the individual child's needs.

(4) provide opportunities for success which are visible to children.

(5) are tools that require the children to examine themselves in terms of their capacity for self- direction. (Contracts can increase in complexity as the children assume greater self-responsibility.)

(6) provide opportunities for interaction between children and foster parents. (The parties are required to make an investment in their relationship. Great patience is required with the children, though, as it will take time for them to succeed.

(7) provide practice for adult life. (For example, the time children return home from outside activities varies according to the child's age. Older children may wish to negotiate times that seem reasonable to themselves but not to the foster parents. The foster parents may sit down with the children and develop contracts (oral or written) which would be satisfactory for both. The negotiations may stall, so it is important to remain flexible but firm.)

(8) represents an investment on the part of both contracting parties.

404.3412 Behavior Management

A second form of discipline available to foster parents is behavior management. If a child is not able to handle the responsibility for self-discipline, the foster parent may need to impose structure and then gradually turn responsibility over to the child. This is usually done through a system of incentives or through a level system. The child receives rewards (privileges or tokens) for approved behavior and can usually work up to a level of increased self-responsibility.

Any behavior management program is to be developed by a professional (social worker, psychologist, family case manager) in consultation with the foster parent as a team member. Any such program is to be reviewed, approved, monitored and modified as necessary by the team.

When developing a behavior management plan, it is good to bear in mind that the system will work best if the rewards are established through mutual agreement of the child, the child's family, foster parent, and family case manager. All must follow the plan consistently.

The child is to be rewarded when the child behaves appropriately. If the child does not perform these behaviors, the child is not rewarded. Under no conditions is the child to be asked to return a reward.

EXAMPLE: Behavior wanted: Brushing teeth before bedtime.

Behavior management: Offer the child a token (penny, poker chip, etc.) each time the child brushes teeth before bedtime.

Reward: After the child has earned 10 tokens, the child will receive the reward (extra TV time, extra bonus in allowance, choice of toothpaste, money, etc.)

404.3413 Corrective Action

The third technique for discipline is corrective action. Before deciding to take corrective action,

the foster parents must decide whether the behavior in question can be permitted or tolerated for a time or ignored in keeping with the needs and progress of the child, the needs of the foster parents, and the seriousness of the behavior. Children must be given opportunities to recognize that their behavior is inappropriate and to control it themselves.

The following presents types of corrective action:

(1) Clarification. In order for disciplinary action to be effective and helpful, it is necessary to make clear exactly what the offense was, when it occurred, the identity of the person(s) who provoked it, the identity of the offender(s), and under what circumstances it took place.

(2) Persuasion. Following clarification, foster parents can attempt to persuade the children to correct mistakes. Foster parents can show the children that there are other ways of achieving goals and that they have the ability to control their impulses. The foster parents' tone must be supportive and dispassionate, emphasizing the real consequences of the offense and suggesting how it can be corrected. The children may be able to suggest ways of correcting their mistakes.

(3) Distraction. Sometimes the simplest way of correcting children is to draw their attention to a substitute activity. The choice of the substitute activity should be guided by some criteria such as your best understanding of the children's intent, their interests, the social acceptability and age appropriateness of the substitute activity and its capacity to diminish the self-defeat of the original activity.

(4) Interference. There are times when foster parents must stop unacceptable behavior immediately. Verbal interference tells the child "since you cannot control yourself, I will help you control yourself". Interference can be social, in the form of accompanying the child to prevent a social act. Physical restraint can be used to prevent injury to another child or damage to property. Physical restraint is to be used

for protection rather than punishment. The Central Office of the Division of Family and Children does not oppose the use of force that is reasonable and necessary to:

(a) stop a child who is threatening physical injury to persons or property;

(b) remove a child causing a disturbance who refuses to cease the behavior or to leave; or

(c) obtain possession of weapons within control of the child in self-defense or in defense of others if the child is actually attacking. If the child is not attacking, a confrontation should be avoided, if possible, by giving the child room, removing others from the area, and obtaining appropriate assistance to disarm the child.

(5) Time-out. Time-out involves removal of children from situations until they can calm down. Children are isolated by having them sit on chairs or stay in parts of occupied rooms or in other unoccupied unlocked rooms under careful supervision. Under no circumstances are closets to be used for time-out. In some situations, it may be more appropriate for foster parents to "take time-out", removing themselves from situations as long as the children's safety is not in question.

(a) Time-out is to be used sparingly, after other techniques have failed to bring children under control.

(b) Time-out is to be short. A rule of thumb for the length of time-out is one minute per year of the child's age; e.g., a maximum of 10 minutes for a 10 year old child.

(c) Once time-outs are over and the children have calmed down, they can return to other activities. It is helpful to bring the children back to something constructive that will redirect their energy.

(6) Withholding privileges. At times, it may become necessary to withhold privileges as a means of changing children's behavior. Privileges are benefits or favors that have been granted to children. Privileges have to be given to children before they can be withheld. Examples of privileges that could be withheld include use of the telephone, walks to the store, television time, etc. Food, shelter, and visits with parents are rights, not privileges; therefore, the child is not to be deprived of these.

(7) Restitution. Restitution is a realistic and simple form of discipline in cases of property damage or theft. Children can pay for repair of the property within reason in relation to the amount of money they have or receive through such sources as an allowance or a part-time job. Children who steal can either return the stolen goods or pay for them.

In the field of foster care, many professionals such as social workers, foster parents and family case managers have long stressed the importance of developing each foster child's potential. Discipline is one method of helping foster children reach their potential.

404.342 Guidelines for Use of Discipline

When any form of discipline is used on a foster child, these general guidelines are encouraged:

(1) Use encouragement and praise whenever possible to reinforce behavior.

(2) Don't take any type of corrective action while you are angry. Wait until your anger subsides before implementing discipline.

(3) There will usually be several discipline options to deal with a specific behavior or set of behaviors.

(4) Set clear limits, rules, and expectations; and communicate these to the children.

(5) If it is possible, have the children take responsibility for their actions and correct the behavior or situation.

(6) Give children choices and involve them in decision-making. This helps children to develop internal controls.

(7) As a general rule, the younger the child, the more immediate the consequences should be.

(8) Some children have physical, emotional, or mental disabilities or limitations that impede their ability to understand what is expected of them and to behave accordingly.

404.4 Independent Living

The goal of independent living is appropriate for youths in care who will eventually experience living on their own. Best practice dictates that youths who are old enough to understand the various skills required to become independent should be provided with the supportive services required to assist them toward self-sufficiency.

404.41 Eligibility

The following criteria have been established to determine the eligibility of youths to receive at least minimum independent living services:

(1) Youths must be age 14-21 and under the supervisory responsibility of the state.

NOTE: Supervisory responsibility includes having a current case plan in each ward's case file.

(2) Foster care maintenance payments must be expended on their behalf currently. This includes per diem payments to group and residential facilities, whether or not the facility is eligible to receive Title IVE-FC funds.

(3) The youths must be expected to be able to live independently eventually.

(4) In order to qualify for independent living services, youths between the ages of 18-21 years must:

(a) be full-time students in a secondary school or in an equivalent technical or vocational program; and

(b) be expected to complete the program before reaching the age of 21 years.

(5) Any youth may receive services for up to six (6) months following discontinuance of foster care maintenance payments through IVE-FC or county wardship funds.

(6) Family case managers are to review case plans and determine if the youths' permanency plans are realistic. Youths whose primary plan

is to move from substitute care to independent living are to have a permanency plan of emancipation.

404.42 Minimum Services

Youths in substitute care under the supervisory responsibility of the state who are 16-21 years of age are to receive independent living services unless staff can document that the youths will more than likely never live independently; i.e., they are severely retarded, have a severe physical handicap, etc.

The Federal Independent Living Initiative of 1986 mandates that all youths in substitute care who are 16 years of age or older be assessed and provided with a service plan specifically addressing issues around transition to independent living. From this assessment of strengths and needs, a service plan can be formulated utilizing input from the family case manager, service provider, caregiver, and the youths.

Each case plan (State Form 2956) for youths who are 16 years of age or older must contain specific goals and content areas to be covered during the period of time covered by the document. This information is to be contained in Section D (1) of the case plan and is to contain, at a minimum, the following services:

(1) Group or individual counseling to deal with independence issues including, but not limited to:

(a) resolution of problems revolving around separation issues.

(b) emancipation issues.

(c) interpersonal relationships and contact with family.

(2) Training to prepare the youth for independence including:

(a) self-esteem enhancement.

Possible approaches:

(i) Individual or group counseling by family case manager, foster parent or residential staff, therapist, or school counselor.

(ii)` Meetings with former wards who have made the transition to independent living.

(iii) Participation in a conference for wards in foster care.

(iv) Positive feedback from the family case manager or other adults regarding accomplishments, strengths and needs.

(b) job skills and vocational plan.

Possible approaches:

(i) Use of vocational testing or career assessment tools through the public school district.

(ii) Participation in individual or group sessions addressing job or career planning and employment-related skills.

(iii) Participation in specialized or individually developed job training programs.

(iv) Job-shadowing.

(c) basic living skills in the areas of money management, health and human sexuality, parenting, problem-solving/decision-making, recreational activities, community systems and services, locating and maintaining housing, home management, and consumerism.

Possible approaches:

(i) Individual modeling; informal teaching by foster parents, residential staff, or family case manager.

(ii) Participation in a formal life skills training course.

(iii) Supervised practice in the skills listed above.

(3) Educational training;

Possible approaches:

(a) Tutoring.

(b) Securing educational evaluations, identifying needs, and developing a plan to address deficits.

(4) Self-identity.

Upon discharge, the young adult is to receive the following package of important documents:

(a) birth certificate;

(b) medical history/information;

(c) listing of foster care placements;

(d) social security card;

(e) school documents;

(f) religious history;

(g) birth family information including parents' death certificates, if applicable.

The family case manager is to coordinate the research for the above documents with the independent living service provider's treatment plan.

Possible additional approach: Use of a life book to understand past experiences.

Staff is to ensure that the Case Plan I [State Form 2956, Section D (3)] contains documentation of any youths who refuse independent living services, including efforts to encourage the youth to participate.

404.43 Permanency Planning

The goal of independent living as a permanency plan is to be established and periodically reviewed for adolescents ages 16 to 21 who are in foster care and for whom reunification with their families, the establishment of guardianship or adoption appears unlikely. The family case manager and independent living service provider will meet within 30 days of a ward's 16th birthday. ICWIS will generate a tickler directed to the family case manager prior to the date this meeting is to occur. The purpose of that meeting is to determine the appropriateness of changing the case goal to independent living by utilizing the following guidelines:

(1) Youths must participate in choosing the goal of independent living.

(2) Those working with youths must help them understand the reasons for setting the goal and convey to the youths that they will receive the support they need to prepare themselves.

(3) These goals are to be reviewed every six (6) months or at any time there is a change in the youths' situation.

Even after the independent living goal is set, those caring for adolescents are to remain aware of any possibility that the youths can be returned home, be placed in guardianship or be adopted and are to take appropriate action to explore that possibility.

404.44 Family Case Manager Role

Family case managers are to assist youths to develop and utilize available resources necessary to prepare for independent living. They are to utilize Independent Living Program service providers, community resources, and any other significant individuals in the youths' lives to assist in this preparation.

When placing youths in family foster homes, group homes, or residential child care institutions, family case managers are to initiate the development of agreements with the contract personnel that incorporate informal independent living concepts into the youths' daily living arrangements. Informal independent living concepts include programs and activities that encourage youth to prepare for life in the community. These include:

(1) problem-solving;

(2) assisting in the preparation of meals;

(3) using public transportation or finding their own transportation;

(4) washing their own clothes;

(5) planning their own leisure activities;

(6) budgeting money;

(7) getting themselves up in the morning.

These services must be provided for those foster care youths for whom the goals of independent living or emancipation have been determined. Many youths in out-of-home care are expected to return home to their families. In reality, all youths in care need to be acquiring independent living skills regardless of the case plan goal assigned.

For younger adolescents, the intangible, personal skills are to receive primary focus while education in basic skills assumes a complementary role. When there is a period of time between the provision of services to prepare wards for independent living and the wards' actual move into an independent living arrangements, family case managers are to develop a method to maintain the youths' independent living skills.

404.45 Youths Placed Out-of-County/Region

Staff is to consider the following options when attempting to arrange independent living services for youths placed outside the county of wardship or the region:

(1) Contact the Regional Child Welfare Service Coordinator for the region in which the youth is placed and request that the youth be included in that region’s Independent Living Program.

(2) If a region has a youth served through another region’s IVE-IL plan, the region in which the youth’s county of wardship is located may provide IVE-IL funds to the region providing services to the youth following the usual procedure.

404.46 Aftercare

Any youths previously eligible for IVE-IL services may continue to receive support services for up to six (6) months following discontinuance of foster care maintenance payments through IVE-FC or county wardship funds.

No later than 90 days prior to emancipation, youths shall receive written notice that wardship will be discontinued. The case plan [State Form 2956) Section D (4)] is to include a listing of the discharge information and services that will be provided such as:

(1) documents previously delineated in subsection 404.42;

(2) listings of community resources, emergency shelter services, advocacy groups, and information and referral services;

(3) available sources of crisis or peer counseling and employment counseling and support;

(4) names, addresses, and telephone numbers of individuals who will always know the youths' addresses.

404.47 Termination of Services

Services must be terminated when any of the following occur:

(1) The youth no longer meets the definition of a child as defined in IC 31-9-2-13(d) of the Juvenile Code.

(2) The youth no longer needs substitute care placement or services.

(3) The youth refuses to participate actively with the development of the case plan or to follow its provisions.

(4) The youth is 18 or older, and is not a full-time student.

(5) The COFC no longer has custody of the ward.

404.5 Other Services

The following information concerns those additional services to children in out-of-home care that are to be provided because of their extreme importance to a child's sense of normalcy and well-being.

404.51 Life Books

A "Life Book" is an account of the life of a child conveyed in words and pictures. Having such a book affords children an opportunity to explore their past and to question, understand, and accept their own life histories. Life books should include, but not be limited to the following:

(1) Actual photographs or carefully selected magazine pictures showing the significant persons, places, home, and events in the child's life.

(2) Important papers or documents, if available; e.g., birth certificates, school report cards, special letters and cards the child received, awards, adoption decree, etc.

(3) Stories and pictures by the child telling of significant events, memories, likes and dislikes;

(4) Anything else that the child feels is important in the child's life.

Life books can be made from spiral notebooks, 3-ring binders, or scrapbooks. It should reflect the child and should be completed in a manner that is comfortable for the child. The life book should be an ongoing project for the child, family case managers, foster parents and adoptive parents which gives continuity to the child's life. Title IV-B funds may be used to support this project. See subsection 1002.52.

404.52 Driver's Training

Indiana statutes do not permit COFC employees to sign an authorization for a ward to take driver's training or obtain a driver's license. Signing such an authorization implies assumption of a liability. COFC employees are prohibited by law from guaranteeing payment of the personal bills of a consumer of agency services, and the COFC has no funds to assume the liability.

However, the child's legal parent or legal guardian may wish to sign such authorization and assume liability. If this is not feasible, the Central Office of the Division of Family and Children (DFC) supports, in principle, the willingness of foster parents to authorize a ward to take driver education and obtain a driver's license. Enabling a foster child to accomplish this goal at the time in a child's life when it is most important as a rite of passage promotes the development of a family environment. However, the foster family needs to understand that it is the family that must assume full responsibility both for authorizing the child to receive driver education and for providing full insurance coverage for the child. The DFC Central Office assumes no responsibility/liability for either authorization or insurance coverage. If the foster parent does sign, it must also be understood that the foster parent is responsible for retrieving the license if the child is moved. It should be noted that a child for whom a driver's license is being sought by foster parents is required to have completed, be attending or be registered for a bona fide driver education program (verification required). The COFC would need to establish a method for monitoring whether insurance coverage is always in place.

If a foster parent wishes to assume responsibility by signing an authorization for a ward to receive driver education or obtain a driver's license, the foster parent shall submit a written request to the COFC for permission prior to giving authorization. The COFC may grant or deny a written request from a foster parent for permission to sign an authorization for a ward to receive driver education or obtain a driver's license. Factors to consider in determining whether to permit or deny foster parents to give this authorization include the following:

(1) Whether the parent or guardian is willing to sign the authorization and provide full insurance coverage and, if not, the reason for it; e.g., the child's past history, or the inability of the parent or guardian to provide full insurance coverage.

(2) Whether the child's parent or guardian will give permission for the foster parent to sign a driver education authorization. This requirement may be waived if it is in the child's best interest to do so, but the COFC would be obligated to notify the parent or guardian of the intent to assist the child to obtain a driver's license.

(3) Whether the foster parent can assume full responsibility for the authorization and full insurance coverage.

(4) Whether it is in the child's best interest to pursue a driver's license while in out-of-home care. For example, is the child considered sufficiently mature to handle the responsibility of driving? Is the child expected to remain in substitute care long enough to warrant pursuing a driver's license while in care?

Using the criteria outlined above, COFCs need to evaluate each situation involving the pursuit of a driver's license for a ward on its own merits and make a decision concerning allowing foster parents to assist a foster child to obtain a driver's license on the basis of that evaluation.

404.53 DFC Liability for Property Damages Perpetrated by a Ward

The state has no funds available to pay for damages to property perpetrated by a ward. In such a situation, the injured party is required to file a standard tort claim in order to collect damages from the state. This does not mean the matter would necessarily go to court.

405 Documentation

While delivery of services to children and families in the best possible manner is the paramount objective of the division, the importance of properly documenting case activity cannot be overstated. The reasons include, but are not limited to:

(1) continuity of service provision.

(2) verification of timeliness with regard to meeting legal requirements.

(3) assuring receipt of all federal monies to maintain and improve services to Indiana's families and children.

405.1 Child Welfare Data Collection

Federal regulations at 45 CFR 1355.40, which implement section 479 of the Social Security Act (the Act), set forth the Adoption and Foster Care Analysis and Reporting System (AFCARS) requirements for the collection of uniform, reliable information on the children who are under the responsibility of the state Title IV-B/IV-E agency for placement and care. Effective October 1, 1994, states are required to collect and

submit data on children in foster care and children adopted under the auspices of the state's public child welfare agency. The AFCARS penalty structure for failure to meet the regulatory requirements was not applicable until the beginning of the fourth year of AFCARS reporting, starting with data submitted for the seventh report period (October 1, 1997 through March 31, 1998).

Federal regulations at Section 479; 45 CFR 1355.40 through 45 CFR 1355.57, which implement section 474 (a) (3) (C) of the Act, set forth the requirements states must meet to receive funding for the planning, design, development, and installation of a statewide automated child welfare information system (SACWIS). Such systems must be comprehensive in that they must meet the requirements for AFCARS, required by section 479 (b) (2) of the Act and implementing the regulations.

405.2 Required Case Record Information

Documentation of information regarding a child in out-of-home care that is required to be in the electronic ICWIS case is delineated in the ICWIS Student Handbook and Bulletin Board, and in the ICWIS information included in the sections of this manual. Information required to be in the paper case record is outlined in the revised Section 11.

405.3 Retention of Case Information

The date when a paper case record would be eligible for transfer to the State Archives is the January following the year in which the youngest child in the case reaches 23 years of age. For example, if the youngest child turns 23 in 1998, January 1999 is when the case will be transferred. In ICWIS, identifying information is purged after the victim child reaches 24 years of age and before the case is archived.

406 Permanency Planning

Federal Title IV-E legislation is designed to eliminate unplanned extended out-of-home placements for children. This legislation is based on the premise that every child requires a permanent home for healthy development. Case planning and review form the procedural structure to ensure that a child does not drift in out-of-home care, but rather that there is continued movement toward the goal of creating a sense of permanency in the child's living situation as rapidly as is conducive to the child's well-being. Refer to subsections 306 and 307 relative to case planning and review.

The decision to return a child home or to seek alternate permanent placement must be based upon a thorough assessment of the child's needs and desires, and a reassessment of the risk and needs of the legal family. Factors to be considered in making such a decision include, but are not limited to whether:

(1) the circumstances that led to the child's initial removal from home have been alleviated.

(2) the child wishes to return home.

(3) the parents want the child to return home.

(4) the goals of the service plan have been met.

(5) sufficiently regular and meaningful visitation has occurred.

The decision to return a child home or to make an alternative plan, such as termination of parental rights and subsequent adoption or guardianship, kinship care, change of custody or institutionalization, is critical. Such an important decision cannot, and is not to be made in a vacuum. Supervisors, directors, foster parents, and other professionals working with the child and the family need to have input into the decision-making process. The family case manager has the responsibility of reassessing risks and needs and initiating permanency planning conferences at appropriate stages of a child's out-of-home placement. Any recommendations for returning the child to the child's home will then need to be presented to the court; and the court, in all cases, will make the final decision.

407 Funding

It is essential that the family case manager have a working knowledge of child welfare funding systems and budget allocations to promote maximum utilization of available resources for the benefit of the children and families served. Limited funds require the family case manager to review all available resources for each child. The family case manager and accounting personnel must communicate on a regular basis.

407.1 Primary Funding Sources

The first resource to be reviewed is the child's own family. The family case manager must request parents to supply information regarding any benefits the child is receiving or is eligible to receive and information regarding the parents' ability to make voluntary support payments.

407.11 Voluntary Support/Reimbursement Payments

Under Indiana law, birth parents are liable for the support of their children. In determining the amount to be contributed by parents, the following factors should be considered:

(1) the costs incurred for providing care for the child;

(2) the financial circumstances of the parents.

The support/reimbursement arrangements agreed upon must be in writing, and each party is to have a copy. The voluntary payments are made directly to the COFC.

407.12 Court-Ordered Support/Reimbursement Payments

When voluntary contributions cannot be obtained from parents who are financially able to make payments, the COFC can make a referral to the court for a determination under the provisions of IC 31-40-1-2. For accounting information regarding these funds, see subsection 407.421. Court judgments may order support/reimbursement payments to be made directly to the COFC, to persons caring for the child, or to the court clerk for appropriate distribution. Payments must be made in accordance with the judgment.

407.13 Social Security (RSDI) and Other Benefits

When the COFC takes wardship of a child who is eligible for or is receiving Social Security in the form of Retirement, Survivor's, and Disability Insurance, (RSDI), or other benefits paid for the care of dependent, minor children, the COFC may apply for, and act as the recipient of these benefits. Social security benefits follow a child even when the child is adopted. If at the time wardship is dismissed or a child is emancipated there are excess Social Security or Supplemental Security Income funds in the child's Trust Clearance Fund, the moneys must be returned to the child or the child's family.

Benefits other than Social Security include:

(1) military allotments;

(2) Railroad Employees' Insurance;

(3) Unemployment Insurance;

(4) Veterans' Benefits;

(5) Workers Compensation.

In addition, a child might be the beneficiary of a will, a trust fund, or a life insurance policy. The child may also be covered for medical costs under a parent's health insurance policy.

407.14 Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is the federally funded aid program for "the needy aged, blind and disabled". A blind or disabled child may qualify for benefits under this program that is administered by the Social Security Administration. A representative from that agency should be contacted for further information.

407.2 Family and Children Fund

Having explored what financial resources are available through the child's family as well as what other community resources might be available to meet the needs of the child, the family case manager may then investigate the use of appropriations from the Family and Children Fund.

The Family and Children Fund provides services to children who are adjudicated CHINS or delinquent, recipients eligible for an informal adjustment (IA) agreement or a services referral agreement (SRA), or children who are receiving adoption assistance.

The following further defines the accounts in this fund:

407.21 #32500 Care of Children in Foster Homes – Includes expenditures for all dependent children placed in foster homes, homes of parent, or homes of relatives. This includes IV-E and IV-A eligible children. Rates for children in foster care with or without special needs and instructions regarding how

to determine a special needs rate are in Appendix L. See Appendix M for the ICWIS Special Needs Checklist.

407.22 #32510 Care of Children in Therapeutic Foster Homes – Includes expenditures to an organization (company or institution) that recruits and trains therapeutic foster
parents and monitors placements in the foster home. This includes IV-E and IV-A-eligible children.

407.23 #32520 Care of Children in Institutions - Includes expenditures for placement in a residential facility, group home, and secure detention, regardless of whether it is an in-state facility or out-of-state facility. This includes IV-E and IV-A-eligible children.

407.24 #32530 Independent Living for Children - Services provided to older teenagers who are adjudicated CHINS or delinquent to enable them to become self-sufficient and prepared for adulthood. NOTE: If funds are paid directly to a child for the child to manage, the funds cannot be reimbursed through Title IVE-FC funds.

407.25 #32540 Preservation Services - Provides services to either prevent children from being removed from the home or to reunite families after removal has occurred. This includes IV-A children. Services include but are not necessarily limited to the following:

(1) Respite Care - Child care for abused, neglected, and delinquent children provided to give parents or foster families a break from the child or children.

(2) Home Based Services - Services provided within the home to the child and/or family.

(3) Counseling - Provided to the child and/or the family.

(4) Other Family Services - Provides for other family preservation services, family education and training, alcohol and drug testing and treatment, medical exams and treatment for non-wards (family members), and other expenses as necessary to avoid removal of children from the home.

407.26 #32550 Miscellaneous Cost of Children - This includes IV-E and IV-A-eligible children and provides for the following services:

(1) Medical, Dental and Burial - Pays for medical and/or dental exams and treatment for wards not otherwise covered by Medicaid. The suggested guideline for burial of a ward is the TANF allowance of $1000 per burial.

(2) Clothing and Other - Pays for clothing, supplies, including school supplies; reimbursement to family case managers for entertainment of wards during visitations, and transportation costs to visit relatives. NOTE: Some of these costs can be reimbursed through Title IVE-FC.

(3) Transfer Tuition and Capital Costs - Pays for:

(a) out-of-state transfer tuition if a ward is attending public school in another state;

(b) education programs to a non-public school; e.g., a school on the grounds of an institution when the educational cost is not included in the institutional per diem; and

(c) capital costs, which are charges for the use of special equipment by a child with disabilities. The equipment must be necessary for the education of that child. This funding source cannot be used for or by any child who is not a child with disabilities.

(4) Monitoring Device - Pays for the use of electronic devices to monitor activities of a delinquent child.

407.27 #32560 Medicaid Rehabilitative Option (MRO) - Provides matching funds for federal participation in the Medicaid Rehabilitative Option. Services for MRO are available only through a community mental health center. A list of services eligible for MRO reimbursement are as follows: diagnostic assessment, pre-hospital screening, individual treatment, conjoint treatment, family treatment, group treatment, med/somatic treatment, crisis intervention, train/active daily living, partial hospitalization, and case management.

Offices are required to budget only the required Medicaid match, and only this match will be paid from the Family and Children Fund.

407.28 #32600 Adoption Services - Includes the IV-E Adoption Assistance Program (AAP) as well as the Indiana Adoption Subsidy for Hard to Place Children.
The Indiana Adoption Subsidy for Hard to Place Children - Pays for non-IV-E-eligible children who are disadvantaged due to ethnic background, race, color, language; physical, mental, or medical disability; age, or membership in a sibling group that should not be separated. (IC 31-9-2-51) See Section 3 of this manual

for detailed information regarding the availability of Indiana Adoption Subsidy Program-only (IASP-only) Medicaid for these children.

Under this program, if:

(1) federal payments for adoption assistance are not equal to the total monthly cost of care in a foster home, or

(2) the child is not eligible for the federal IVE-AAP,

the court may order the support of the adoptive child in an amount not to exceed the monthly cost of care of the child in a foster home under this program.

This program is also a subsidy to IVE-AAP, which limits payments to 75% of the per diem amount. The remaining 25% could be paid under this program.

Also, the court is authorized to order a subsidy to continue until the adoptive child becomes twenty-one (21) years of age if:

(1) the adoptive child files a petition for the order; and

(2) the court determines that the child is enrolled in a:

(a) secondary school;

(b) college or university; or

(c) course of vocational training leading to gainful employment.

Adoption Assistance - Provides a subsidy for adoptive families with IV-E-eligible children with special needs. The amounts to be paid under this program are the greater of $13.50 per day, or 75% of the per diem amount which is being paid by the county having wardship of the child for foster home care.

407.29 #32700 Foster Parent Insurance - Provides payment for the insurance available through the Indiana Foster Care and Adoption Association (IFCAA). Title IV-B-Part I funds can be used to pay for this insurance. If these funds are used for this purpose, the intent to do so must be included in the Title IV-B-Part I Plan; and the funds must come from the capped foster care maintenance portion of the allocation.

NOTE: The following accounts are currently located in the Welfare Fund. However, effective July 1, 2000, they will be located in the Family and Children Fund. In the interim, monies from the accounts in these two funds cannot be transferred from one fund to the other.

Monies in each fund can be transferred between accounts within each fund but not between the funds.

407.210 #30020 Healthy Families Indiana (HFI) - A voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care, and parent education.

The services are home-based, and potential participants are identified prior to or at the time of birth.

407.211 #30080 Destitute Children - Payment for needy children who are not wards and who are under the age of 18 and deprived of parental support or care by reason of death, continued absence from the home, or the physical or mental incapacity of a
parent. Payment levels are to be determined by the Division Director. Per diem payments may be made up to the normal foster care rate.

407.212 #30090 Child Welfare Services - Payment to develop, establish, extend and strengthen child welfare services for the protection and care of dependent and delinquent children and children in need of services. This includes, but is not limited to:

(1) Information/education, including general parent health, prenatal education, and information on child care;

(2) retainer fees for Intermediate Boarding Homes;

(3) Community Awareness Programs

(4) camping for underprivileged children;

(5) travel allowance for underprivileged children and parents to visit; and

(6) Foster Parent Training and Recognition and Family Support Services.

Matching dollars for Step Ahead for a child who is not a CHINS, a delinquent, or a child under an informal adjustment (IA) agreement or services referral agreement (SRA) can also be paid from this account.

407.3 Other Sources of Funding

The following is a list of additional sources of funding for child welfare:

407.31 Title IV-A: Temporary Assistance to Needy Families (TANF)

Assistance for dependent children in the custody of relatives can be paid with Title IV-A federal funds through the Temporary Assistance to Needy Families (TANF) entitlement program. Refer to the Indiana TANF Manual for eligibility requirements of the program.

407.32 Title IV-A: Emergency Assistance (EA) - Provides federal matching funds. Services can be provided through this program on an emergency basis for 180 days in a 12-month period. Eligible services include out-of-home placement, counseling, home-based services, other family services, some medical expenses, and clothing. Refer to Divisional Policy Directive #5-A-002 under "Community Based Services and Programs: Public Assistance".

407.33 Title IV-B: Child Welfare Services (CWS)

Under Title IV-B of the Social Security Act, federal funds are made available to the states in the form of annual grants for Child Welfare Services. The funds are divided into subparts to be used for different purposes as described below. In Indiana, the Central Office of the Division of Family and Children administers these funds.

407.331 Subpart I

Title IV-B-Subpart I funds are used for administrative expenses, statewide contracts such as those for family case manager training, and for regional services. The regional services are planned and contracted through a regional committee. Title IV-B may be used to benefit individual children or groups of children, but must be related to child abuse or neglect issues or services. See Section 10 for further information.

407.332 Subpart II

Title IV-B-Subpart II funds are used for preservation and support services (family support), crisis intervention (family preservation), time-limited reunification services and adoption promotion and support services. Funding for these services are distributed through local Step Ahead committees.

407.34 Title IV-E: Foster Care (FC) Provides federal matching funds calculated using the federal medical assistance percentage rate. Funds can be used for the care of eligible children who have been removed from their homes pursuant to a judicial determination.

407.35 Title IVE-FC: Waiver Demonstration In 1995, the federal government announced a demonstration project in which 10 states would be allowed to request waivers of select sections of the Title IV-E program. Indiana filed a proposal to waive five (5) specific selections with the goal of making it possible, through increased funding flexibility, for more children to be served in their local communities rather than being placed in restrictive settings. Restrictive care, in this context, includes foster family home, group home, and institutional settings.

Indiana received approval for four of the five waiver requests on July 18, 1997. Detailed information concerning the project can be found in an administrative letter dated December 15, 1997, entitled "IV-E-FC Waiver Demonstration Project". The savings produced as a result of a reduced number of placements in restrictive settings can then be used to develop new, or pay for already existing home-based, intensive services. These wraparound services are intended to prevent out-of-home placements and further abuse and neglect.

75% of waiver slots are designated for children who are eligible for traditional Title IV-E benefits or who can meet IV-E eligibility requirements under the waiver. 25% of the waiver slots are designated for children who cannot meet the

requirements for traditional IV-E benefits or benefits under the waiver. See Appendix N for a program comparison of waiver and non-waiver children.

407.36 Title IV-E: Adoption Assistance Program (AAP) Provides federal matching funds to adoptive parents calculated using the federal medical assistance percentage rate. These funds are provided to assist adoptive parents in covering expenses associated with meeting the special needs of the adoptive child.

407.37 Refugee Act of 1980 Funds

The Refugee Act of 1980 provides federal reimbursement to the states for costs in the settlement of refugees. Subsection 1005 of this manual describes this program relating to unaccompanied minor refugee children.

407.38 Health Facilities

IC 12-15-2-9 enables eligible persons who are under age 21 and in Medicaid-certified psychiatric facilities to receive medical assistance. It also extends eligibility to persons in Medicaid-certified intermediate care facilities for the mentally retarded (ICF/MR). In both categories, the child must be receiving active treatment in a Medicaid-certified facility and must meet Medicaid eligibility requirements. For further details, refer to the Indiana Medical Assistance Manual.

407.39 Medicaid

IC 12-15-2-16, IC 12-13-8 and IC 12-13-9 make available medical assistance (Medicaid) to children who are adjudicated to be in need of services (CHINS) or are under the custody or supervision of a county office of family and children as ordered by the court. There are several Medicaid categories that are available to benefit children. For example, children who are eligible for Title IVE-FC and Title IVE-AAP benefits receive Medicaid coverage through those programs. See Sections 9 and 8 respectively for detailed information regarding these programs.

407.391 Medicaid for Wards

The intent of this program is to provide for costs of medical care for children who meet financial eligibility requirements but do not qualify to receive Medicaid benefits under any other category of medical assistance. Due to the special funding mechanism that includes county financial participation, children are to be covered under this category only if they do not qualify under any other category of medical assistance. For more specific procedures regarding this program, refer to Section 3 of this manual.

407.392 Medicaid for Indiana Adoption Subsidy Program (IASP)

Effective 7/1/99, this program extends Medicaid coverage to non-IV-E-eligible special needs children who receive only a court-ordered adoption subsidy under Indiana's program for adoption of hard to place children. (IC 31-19-27) This Indiana Adoption Subsidy Program-only (IASP-only) Medicaid applies to adoptive children who are not eligible for the Title IVE-Adoption Assistance Program (AAP) but who are disadvantaged due to ethnic background, race, color, language; physical, mental, or medical disability, age, or membership in a sibling group that should not be separated. (IC 31-9-2-51) See

Section 3 of this manual for detailed information regarding this Medicaid program.

407.310 Hoosier Healthwise for Children

Hoosier Healthwise is a health insurance program for children, pregnant women and low-income families that is offered through the Family and Social Services Association. In operation since 1994, the program was expanded in 1998 to provide coverage to all children below the age of 19 who live in Indiana and who live in a family that earns at or below 150% of the federal poverty level. Benefits include primary and preventive care, doctor visits, hospital stays, prescription drugs, vision and dental care, mental health care, and other important benefits for children. The program also has benefits for children with special health care needs such as asthma and diabetes. To apply, families may go to an enrollment center in a hospital, mental health center or other location frequented by families with uninsured children who may be eligible for this program. A separate health insurance plan for children above 150% of poverty, with premiums and co-pays, is available.

407.311 Hoosier Assurance Plan for Seriously Emotionally Disturbed Children and Adolescents

The Division of Mental Health's Hoosier Assurance Plan (HAP) is designed to equalize the availability and quality of community-based mental health and addictions services for seriously emotionally disturbed (SED) children and adolescents across the state. To accomplish this goal, the Division of Mental Health contracts with managed care providers to provide an array of services to this population.

In order to be eligible for this program must:

(1) be at or below 200% of the poverty level;

(2) have a mental illness diagnosed under DSM III-R or DSM IV after 1/1/95;

(3) have experienced significant functional impairments in at least one (1) of the following areas:

(a) activities of daily living;

(b) interpersonal functioning;

(c) concentration, persistence, and pace; or

(d) adaptation to change; and

(4) have a mental illness, the duration of which has been, or is expected to be in excess of 12 months. However, children who have experienced a situational trauma and who are receiving services in

two (2) or more community agencies do not have to meet the durational requirement of this clause.

Services in the array of care include:

(1) individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed below.

(2) 24-hour a day crisis intervention.

(3) case management to fulfill individual patient needs, including assertive case management when indicated.

(4) outpatient services, including intensive outpatient services, substance abuse services, counseling and treatment.

(5) acute stabilization services.

(6) residential services.

(7) day treatment.

(8) family support services.

(9) medication evaluation and monitoring.

(10) services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.

407.312 County Welfare Trust Clearance Fund

This fund is established by the Welfare Act and is used for purposes as provided in IC 12-19-1-14 through IC 12-19-1-16. There are no public monies in this fund. Sources of revenue for this fund are as follows:

(1) Money available to or for the benefit of a person receiving services from a COFC, such as parental support payments, SSI, or inheritance received for a particular child receiving child welfare services may be deposited in the county welfare trust clearance fund. Money that is received for the purpose of reimbursing the county for expenditures for services for a child may not be deposited in the trust clearance fund. Payments for services provided to a child should not be made from this fund. Payments are to be made from the appropriate account in the Family and Children Fund, or from the Welfare Fund while there are child welfare-related accounts remaining in it. See subsections 407.210-212. Those accounts can then be reimbursed from the child's trust clearance fund.

(2) Gifts, devises or bequests of personal property and voluntary contributions may be used for the benefit of:

(a) any home or institution for dependent or neglected children who are under supervision of the county office of family and children (COFC); or
(b) any children who are committed to the care and supervision of the COFC.

These monies may not be commingled with other funds and shall be spent only with the approval of the COFC and the probate court.

407.313 Adoption Trust Clearance Fund

Placement fees from adoptive parents as described in subsection 718 of this manual are entered into this fund. Monies may be used for the care of children whose adoption is contemplated and for the improvement of adoption services provided by the COFC. Services may include, but are not limited to:

(1) Te care of children whose adoption is contemplated. This includes per diem for placement in a pre-adoptive home.

(2) maternity care for mothers considering adoptive placement.
adoption training.

(3) purchase of training materials for prospective adoptive parents.

APPENDIX – SECTION 4

A. Family and Social Services Administration Service Entry Points

B. FY 2000 Hoosier Assurance Plan: Managed Care Providers, CMHC's with MRO, and Populations

C. Integrated Field Service Offices (DDARS)

D. First Steps Local Council

E. Local Coordinating Committee Forms and Instructions

F. Family Case Manager Contact Standards

G. ICWIS Visitation Plan Format

H. General Information About AIDS and HIV Infection/Preamble and Rationale: HIV Policy for Foster Care

I. Indiana Code: Communicable Diseases

J. Blue Book and ICWIS Medical Passport

K. Sample Consent to Release Mental Health Records Form

L. Title IV-E Foster Care Rates

M. ICWIS Special Needs Checklist

N. Universe of Children: Waiver/Non-Waiver

APPENDIX H

GENERAL INFORMATION ABOUT AIDS AND HIV INFECTION

What is AIDS?

The acquired immunodeficiency syndrome (AIDS) is the final stage of infection with the human immunodeficiency virus (HIV). This virus infects and, over time, destroys certain white blood cells (CD4 cells) in humans. These cells control an important part of the body's immune system (cell-mediated immunity). As CD4 cells are destroyed, the immune system becomes impaired, ultimately making HIV-infected persons susceptible to infections with certain "opportunistic" organisms and cancers. These infections and cancers are considered "opportunistic because they either do not occur at all or occur in much milder forms in persons with normal immunity. It is important to realize that the destruction of the immune system by HIV is a slow process and occurs over several years. A majority of HIV-infected adults looks and feels healthy for eight to ten years or more before developing AIDS.

Children, particularly those born with HIV infection, may become sick sooner and fare worse overall than adults and older children. Advances in diagnosis and treatment have lead to prolonged life; and HIV infection in children is now a chronic, and not an acute or a short-term, illness.

The infections and cancers associated with AIDS do not usually cause serious disease in persons with normal immune systems, and most are not contagious to other persons. The Centers of Disease Control (CDC) has a list of the infections and cancers that indicate that an HIV-infected person has AIDS.

How is HIV transmitted?

HIV is transmitted through sexual intercourse and through contact with infected blood or specific infective body fluids. This is because blood, semen, and vaginal secretions contain large amounts of HIV. Other body fluids, such as saliva, nasal secretions, urine, feces, and tears, do not contain virus in large enough amounts to be infectious. If these "safe" body fluids are visibly contaminated with blood, however, they must be considered infectious because of the potential for blood to transmit HIV.

Other body fluids, such as cerebral spinal fluid (CSF), amniotic fluid, and pericardial fluid, contain HIV in significant amounts and are potentially infectious. These fluids are usually handled only in special settings (hospitals, emergency rooms, operating rooms, etc.) and with special precautions. Breast milk can be infectious, and HIV-infected women or women at risk for HIV infection should not breastfeed their babies.

Another route of transmission is called perinatal transmission in which a pregnant HIV-infected woman can infect the infant she is carrying in utero during pregnancy or delivery. Children born to a woman before she became HIV-infected are not at risk. Many studies have shown that family members of HIV-infected persons are not at risk of acquiring HIV from normal household contacts and activities unless they are the sexual or needle-sharing partners of the infected persons.

Not all exposures to infected fluids cause infection with HIV. While some persons have become infected from a single episode of sexual intercourse, or even from artificial

insemination with infected semen, others have had many episodes of intercourse with an infected partner without becoming infected. The chance of becoming infected from a single needle stick exposure is about 0.3% (MMWR, 12/22/1995). The risk from a contact of a mucous membrane (eye, mouth) with infected blood is 0.mea. Research shows that without prenatal HIV treatment, there is a 22.6% chance of perinatal (mother to infant) HIV transmission. Research has proven that a three-part regimen of antiretroviral medications decreases perinatal transmission to less than 8%. The three-part regimen consists of the mother taking antiretroviral medications beginning after the twelfth week of gestation, and then during labor and delivery, followed by giving the newborn medications for the first six weeks of life.

What are risk factors for HIV infections?

Persons are at risk for HIV infection primarily because of the following activities:

(1) **Sexual intercourse**

All forms of intercourse-oral, vaginal, or anal, are capable of transmitting HIV. Anal intercourse is considered particularly risky because the rectal mucosa is easily broken, and tiny breaks in the skin allow HIV to enter the blood stream. As in other sexually transmitted diseases, men are more efficient transmitters than women. However, since cervical cells and secretions contain HIV, men are a risk of acquiring HIV from infected female sexual partners. The presence of genital ulcers also increases the risk of HIV transmission because the skin is broken in the area of the ulcer.

It is important to realize that the risk of HIV infection comes from repeated exposures to infected partners and is not related to sexual orientation or practices. Two uninfected persons may have any sort of intercourse they choose with each other without becoming infected with HIV.

By creating a barrier, condoms help prevent transmission of HIV during all forms of sexual intercourse. The use of condoms is strongly recommended for all forms of sexual intercourse when the HIV status of one or both partners is unknown.

(2) **Intravenous drug use (IVDU)**

In many parts of the country, the incidence of HIV infection among drug users is very high due to the practice of sharing needles containing HIV-infected blood. In addition, a drug user infected with HIV from sharing needles may transmit HIV to sexual partners. Consequently, the sexual partners of injection drug users are at high-risk of HIV infection whether or not they use drugs themselves. Over seventy percent (70%) of children with HIV infection acquire the disease <u>in utero</u> or at birth from women who use drugs or are sexual partners of intravenous drug users.

(3) **Accidental exposure to infected blood**

Health care workers may be exposed to contaminated needles and other sharps in the line of duty. Although such occupational exposures are fairly common, the risk of developing HIV from a needle from an infected person is about 0.3%; and health care workers, even those providing care for persons with AIDS (PWAs), are <u>not</u> a high-risk

group for HIV because of their occupation. Universal precautions; i.e., the use of appropriate barrier precautions in handling all blood or other potentially infective body fluids, are mandated by Indiana state law to further reduce the risk of occupational HIV infection.

HIV may also be transmitted through the use of infected blood or blood products as a therapeutic infusion. The screening test of HIV became available in 1985. However, hemophiliacs and others who required blood products prior to March, 1985, were at high-risk for HIV infection. Screening the blood supply and heat-treating clotting factors has made the use of blood products much safer; and today, HIV is rarely transmitted by therapeutic transfusions.

Is there a test to see if someone is infected with HIV?

There are simple blood tests that detect antibodies made by the body in response to the presence of HIV. While most infected persons make antibodies within three (3) months of infection, some persons may take six (6) months or more. Because of the time it takes to make antibodies after infection with HIV, antibody tests may be falsely negative early in the course of infection. Infected persons who test negatively early in the course of their infection are still infectious and should take precautions to prevent transmission until their status is clearly determined. Test results are usually reliable six (6) months after initial infection with HIV.

The most widely used antibody test is the Enzyme Linked Immunosorbent Assay, referred to as the ELISA. This test is relatively inexpensive, quick, and easy to run and is used as a screening test for HIV infection. No test is perfect; and although the ELISA is over 99% sensitive and specific, it is possible to have false positive as well as false negative tests. A false positive test means that a person is not infected with HIV but has a positive ELISA.

If an ELISA is positive, it is to be repeated. If the repeat test is also positive, a second, confirmatory test is to be run. The most common confirming test is called a Western Blot. This test is more difficult and expensive to perform and is used to confirm repeatedly positive ELISAs.

It is possible, desirable, and usually less expensive to perform all necessary tests; i.e., the first ELISA and, if necessary, the repeat ELISA and Western Blot, from one (1) sample of blood. If ordered in this manner, it is not necessary to recall a person for further blood draws if the first ELISA is positive.

To be identified as HIV seropositive, which means that a person is HIV-infected, a person must have a repeatedly positive ELISA and a positive Western Blot. No one is to be told that they are HIV-infected on the basis of an ELISA alone.

To determine whether infants up to 18 months of age are HIV-infected, the viral load test (RNA PCN or DNA PCN) is used as a diagnostic tool. It is a more accurate test for infants of this age than HIV antibody testing. HIV antibody testing is used for children more than 18 months of age because it, is not reliable in infants for the first 15-18 months of life. HIV seropositive (infected) mothers may pass their maternal antibodies to their babies causing the newborns to test positively for HIV whether or not they are actually infected. Some infants of infected mothers may not have these passively acquired maternal antibodies at birth but may be HIV-

infected. Babies normally begin to produce antibodies of their own by 15 to 18 months, and antibody tests may be considered reliable after that time.

What are the stages of HIV infection?

HIV infection is a long-term, chronic disease. The Centers for Disease Control (CDC) has developed four (4) stages of HIV disease in adults and adolescents (over 13 years old):

(1) **Acute**

Persons with acute (new) HIV infection often develop fever, malaise, enlarged lymph nodes, and rash several weeks after infection. These symptoms are not specific for HIV and are indistinguishable from other viral illnesses. This acute illness resolves on its own after several weeks. The HIV-infected person apparently regains normal good health and gives no sign of being infected. Since this stage is not specific for HIV, persons with no know risk or exposure should not be alarmed if they develop a typical viral-type illness. Persons with a known exposure to HIV, however, should be alerted to see their physician if such an illness develops soon after their exposure. HIV antibody tests are often negative during acute infections, and repeated testing over time is necessary.

(2) **Asymptomatic**

Persons with HIV-infection may be without signs or symptoms of disease for 10 years or more. A study done in San Francisco showed that eight (8) years after infection with HIV, 48% of persons developed AIDS, others had some symptoms of HIV infection, but about 20% still looked and felt well. Asymptomatic persons may still pass HIV to their sexual and needle-sharing partners, or in the case of pregnant women, to the infants they are carrying in utero.

(3) **Generalized lymphadenopathy**

Some HIV-infected persons feel entirely well but have multiple enlarged lymph nodes (glands). It is unclear whether or not enlarged nodes without other health problems indicate advancing HIV infection.

(4) **Symptomatic HIV infection**

This stage of infection includes all persons with symptoms of HIV disease whether or not they have AIDS. Thrush (Candida), if it appears in the esophagus, bronchia, trachea or lungs, is considered to be an opportunistic infection and an indicator disease for AIDS. Other symptoms commonly associated with HIV infection, such as night sweats, unexplained fevers, loss of appetite, weight loss, rashes, diarrhea, fatigue and enlarged lymph nodes, are not specific to HIV. No matter how sick a person may be, CDC requires an indicator disease to be present before the diagnosis of AIDS can be made.

Is HIV infection the same in children?

The CDC has developed a separate classification system for the pediatric age group (under 13 years of age).

(1) **Indeterminant infection**

Asymptomatic infants less than 15 months of age who have positive HIV antibody tests may not actually be infected. They may have "passively" acquired antibodies through the placenta from their HIV-infected mothers. Infants should be tested at one (1) month, two (2) months and six (6) months of age or greater with a viral load test. Two (2) consecutive negative tests confirm that an infant has not acquired HIV from the mother.

(2) **Asymptomatic infection**

These children are truly HIV-infected but are without signs or symptoms of HIV-related disease.

(3) **Symptomatic infection**

Similarly, HIV-infected infants and children of any age may have a variety of HIV-related infections and conditions, some meeting the diagnostic criteria for AIDS and some not.

What are the common AIDS-related infections and cancers?

Common opportunistic infections in the pediatric and adult/adolescent age groups which fill the diagnostic criteria for AIDS include:

(1) Pneumocystis carinii pneumonia - the most common AIDS-related infection, occurring in 70% of pediatric cases.

(2) Candida, esophageal or bronchopulmonary (thrush in the esophagus or airways). - NOTE: thrush only in the mouth, while common, is not an indicator disease for AIDS. Many bottle-fed babies have thrush in their mouths and are not HIV-infected. In most of these cases, better cleaning of nipples eliminates the problem; and medication is rarely needed. Infants with HIV may have more severe or extensive thrush that requires medical treatment.

(3) Chronic herpes - Herpes simplex viruses (HSV) cause the common "cold sore" as well as genital herpes. While most children have cold sores that heal without medical treatment, herpes in adults and children with HIV infection can cause severe, large spreading ulcers that do not heal without medical therapy. Perinatally acquired HSV disease must be excluded in infants suspected of having chronic herpes.

(4) Cytomegalovirus (CMV) - a common virus that causes self-limited illness in persons with normal immune systems but that can cause serious disease as well as blindness in HIV-infected adults and children. Congenital CMV disease may need to be excluded in some infants.

(5) Mycobacterium tuberculosis(TB) - TB which has spread throughout the body is associated with HIV infection. It is important for HIV-infected persons to be routinely screened for TB because TB in the lung (pulmonary TB) or throat is very infectious to

other persons, even if they are not HIV-infected. In addition, TB in HIV-infected persons responds readily to treatment.

(6) Atypical mycobacteria - "cousins" of TB, these also cause disease in HIV-infected persons. Unlike TB, the atypical mycobacteria are not transmitted from person-to-person, even if in the lungs or throat.

Common cancers include:

(1) Kaposi's sarcoma - appears as multiple purplish nodules in the skin, and often involves lungs, intestines, and other viscera.

(2) Lymphoma - a cancer that can occur only in the brain but is also found outside the central nervous system. **NOTE:** All persons with lymphoma do not have AIDS, but HIV-infected persons with lymphoma have AIDS.

When tissue or microbiologic data are necessary to make the above diagnoses, two (2) other syndromes indicate AIDS:

(1) Wasting - unexplained weight loss and debilitation.

(2) Dementia - alterations of mental functioning not caused by any reason other than HIV infection.

Children with HIV infection are particularly prone to central nervous system dysfunction and may have loss of developmental milestones, developmental delays, as well as general failure to thrive.

In addition, pediatric AIDS includes the following:

(1) Pulmonary lymphoid hyperplasis (PLH)

(2) Lymphoid interstitial pneumonia (LIP).

(3) Recurrent serious bacterial infections - at lease two (2) episodes within a two (2) year period of septicemia, meningitis, or other serious infections (including otitis media).

How can I keep from getting HIV infection?

Most persons are infected from personal behaviors that are controllable. Since HIV is primarily a sexually transmitted disease, one way of preventing acquisition of infection is through sexual abstinence. If a person chooses to be sexually active, is not HIV-infected, and has sexual relations with only one sexual partner who is also monogamous and uninfected, the risk of acquiring HIV from sexual intercourse is very small. It is not zero, however, because it is difficult to know a person's HIV status and even more difficult to know if that person is entirely monogomous. The use of condoms, with or without the spermicide nonoxynol-9, for every episode of sexual intercourse will greatly reduce risk of HIV infection when a partner's HIV status is positive or uncertain. The failure rate for condoms in preventing pregnancy is about

15%, and this may be true for prevention of HIV transmission where one partner is known to be infected.

In an ideal world, all persons using illicit injection drugs would stop using. Since such a scenario is unlikely, drug users who do not intend to alter their behavior or who are waiting to enter a detoxification program should avoid sharing needles. Another option, if needle-sharing is expected to continue, is to cleanse needles and "works" before and after every use with a solution of bleach and water.

The risk of acquiring HIV from a blood transfusion is very small, about one (1) in 600,000. If this remains a concern, and if one's physician feels it is safe to donate blood, persons anticipating elective surgery may give their own blood for their own anticipated use (autologous donation). Hemophiliac and other clotting factors are now heat-treated and should not transmit HIV.

Health care professionals have a small but significant risk for occupational acquisition of HIV infection. This risk can be further reduced by careful technique during procedures and by the application of universal precautions.

Universal precautions are infection control measures taken by health care workers with all persons, regardless of HIV status. Numerous studies have shown that only 10-15% of HIV-infected persons is aware of their infection. In addition, it is impossible to determine who may or may not be HIV-infected from their age, race, sex, appearance or sexual orientation. Risk assessment may not be reliable unless skillfully done; and, on occasion, emergency situations prevent accurate gathering of medical history. Therefore, it is safest to assume that all persons requiring health care could be HIV-infected.

Universal precautions consist of the use of appropriate barrier precautions to prevent direct contact with blood, semen, vaginal secretions, visibly bloody body fluids, or other special fluids such as spinal fluid, which contain large amounts of HIV. In the family, school, or home setting, the main risk of HIV transmission occurs from exposure to infected blood. Body fluids such a tears, saliva, urine, feces, vomitus, and nasal secretions, if not visibly contaminated with blood, are <u>not</u> infectious; and gloves or other barrier precautions are <u>not</u> necessary for routine child care, including diapering/toileting, feeding, burping, et al. These same body fluids, if visibly contaminated by blood, should be considered potentially infectious; and universal precautions should be applied. All persons whose occupations make it likely that they will have contact with blood should be taught how to apply universal precautions. In most cases, this is very simple; e.g, putting on a pair of gloves when cleaning up after a bloody accident. Whether or not barrier precautions are used, hand washing should always be done following contact with body fluids to prevent the spread of any infection the fluids might contain.

In the home, HIV is readily killed by heat achievable in dish washers and clothes dryers. In addition, many common household agents such as Lysol or hypochlorite bleach will effectively eliminate HIV. A solution of one (1) part bleach to 10 parts water is inexpensive and effective on hard surfaces. If blood is on a rug or upholstery, most commercial cleaners or disinfectants will eradicate the virus. In any case, HIV does not survive for prolonged periods outside the body. Dried blood or other stains of uncertain origin need not be considered infectious for HIV.

PREAMBLE AND RATIONALE
HIV Policy for Foster Care

The increased prevalence of HIV infection in Indiana requires that state agencies serving children develop and adopt policies regarding the delivery of services to children with documented or suspected HIV infection.

Federal Anti-discrimination Law

The United States Supreme Court has ruled under Section 504 of the Federal Rehabilitation Act that a communicable disease may be a handicapping condition. Under this act, persons with contagious diseases cannot be discriminated against if they are "otherwise qualified" to be employed or to participate in programs covered by Section 504. Public, private, and voluntary agencies that receive federal funding to care for children; e.g., funds from Titles IV-A, IV-E, and XX of the Social Security Act, are covered by Section 504.

The Department of Health and Human Services has taken the position in its Notice to Recipients of Financial Assistance from the U.S. Department of Health and Human Services that federal civil rights laws apply to persons with HIV infection. In addition, the Supreme Court, in Bragdon vs. Abbott, ruled that the Americans with Disabilities Act (ADA) protects individuals with HIV from discrimination. Indiana's civil rights laws provide protection also.

Definitions

The Human Immunodeficiency Virus (HIV) is the causative agent of the acquired immunodeficiency syndrome (AIDS). HIV infection weakens the body's immune system until the affected person develops "opportunistic" infections and cancers not found in persons with normal immune systems. Morbidity and mortality in persons with advanced HIV infection or AIDS are caused by these infections and tumors and not by HIV itself.

The diagnosis of AIDS is based upon diagnostic criteria established by the Centers for Disease Control (CDC). For the purpose of this policy, a child is HIV-infected when the child:

(1) who is less than 18 months of age has a positive viral load after appropriate testing;

(2) who is at least 18 months of age has positive blood antibody tests; or

(3) has clinical signs and symptoms of immune deficiency conditions associated with HIV.

A child shall be considered as having AIDS when the child fulfills diagnostic criteria.

Transmission

Social workers and direct care providers can safely care for HIV-infected children by using simple hygiene practices. Such practices consist primarily of the appropriate use of disposable gloves and disinfectant. Given the use of these hygiene practices as appropriate, it is safe for workers and caregivers to carry HIV-infected children in their arms, transport them in a car, hug them, hold their hands, dry their tears, or give them a kiss. These practices are also safe for the HIV-infected child.

Not one case of HIV infection is known to have been transmitted in a school, day care, or foster care setting. HIV infection is not spread through the kind of non-sexual contact persons normally have in the home, school, or office; e.g., touching, hugging, or sharing meals, bathrooms, or telephones. This is supported by long-term studies of family members of both adults and children with HIV infection. Not one household member has become infected through routine, non-sexual contact with a family member with AIDS. In addition, there is no evidence that siblings of an HIV-infected child are at risk for acquiring HIV infection from that child.

Confidentiality

Indiana Code IC 16-41-8 protects the confidentiality of positive HIV status. Agencies will establish clear policies and procedures to maintain the privacy and confidentiality of HIV-infected children, noting that the law protects the confidentiality of HIV status. Dissemination of information concerning an infected child's condition will occur only when necessary to assure proper care of the child and to protect others from increasing their risk of becoming HIV-infected. In general, caregivers and staff who work closely with an infected child have a right to know that the child is HIV-infected, although, unlike confidentiality, this right is not mandated by law. It is believed that clear and accurate information about HIV infection, a child's health status, and appropriate infection control measures must be given to parents, foster parents, guardians, or custodians to enable them to make an informed decision about their ability and willingness to provide care to the child. If possible, caregivers and staff will be informed of the child's condition in advance of an assignment involving the child. Agency requirements concerning client privacy and confidentiality of information will also be clearly communicated to those informed of a child's HIV infection.

Serving Children with HIV Infection

Based on the preceding information, agencies will provide or arrange services for any HIV-infected child under their care in a manner that protects the child's rights and well-being and minimizes the risk for further HIV transmission.

The decisions regarding the type of care setting for HIV-infected children will be based on:

(1) the presence of behaviors likely to transmit HIV infection (Based upon experience with other communicable diseases, a theoretical potential exists for transmission among children who are not in control of their body functions or behaviors, such as fighting or biting.);

(2) the age of the child;

(3) the child's medical status, history, and symptomatology;

(4) the need to protect the HIV-infected child from preventable exposures to additional infections;

(5) the appropriateness of existing services and structure; and

(6) whether another agency is better able to provide necessary services to a particular child.

Recommendations for the HIV-infected child's service plan must be based on a comprehensive review by a multidisciplinary team that includes social and medical input to assure that the special needs of a handicapping condition can be met through creative programming or that such programming can be developed.

For most infected school-age children, the benefits of an unrestricted setting outweigh the risk of their acquiring potentially harmful infections in the school setting. The risk of transmission of HIV in the school setting is so small as to be non-existent. Nevertheless, because many infections in addition to HIV can be present in blood and body fluids, all schools and child care facilities are to adopt policies and procedures for handling all blood and body fluids that are in accordance with state law. In general then, HIV-infected children are to be allowed to attend school and child care and to be placed in a foster home in an unrestricted setting.

Regarding the infected preschool-age child, for some handicapped children who lack control of their body secretions or who display aggressive behavior, and for those children who have open lesions which cannot be covered, a more restricted environment is advisable.

NOTE: The hygienic practices of children with HIV infection may improve as the child matures but may deteriorate if the child's condition worsens. Therefore, ongoing evaluation is necessary to assess the need for a change of placement to an environment that is either more of less restricted.

The reason(s) for withholding any service to an HIV-infected child are to be documented, and a recommendation for a specific alternative care plan must be included in the documentation. Permanency planning for clients with HIV infection is to take place in the context of their medical condition and prognosis. Planning is to be based on knowledge of disease states, progression of the disease, and family support needs. Final decisions on disposition plans and acceptance into any specific agency service will be subject to administrative review and approval.

Education and Training

Agencies are to develop or arrange for the provision of programs designed to educate children and their families about HIV infection and transmission and about available psychosocial supports. Agencies will also conduct or arrange for ongoing training and education for employees and contract providers on diverse and appropriate topics surrounding HIV infection. In addition, employees and contract providers will be given a point of contact within their agency where they can call to obtain further information or to discuss situations which arise in their work units.